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ORAL REGRESSION AS MANIFESTED AND TREATED ANALYTICALLY IN GROUP PSYCHOTHERAPY

MORRIS GOODMAN, Ph.D.,¹ and MALCOLM MARKS, Ed.D.²

Group psychotherapy as a medium of psychoanalytic treatment has been subjected to question not only by the devotees of neo-Freudian and classical analytic schools but also by the practitioners and theorists of group psychotherapy itself. Slavson (1956) has stated that psychoanalysis cannot be done in the group setting. Ackerman (1954) suggests that the number of participants and their different social roles in relation to each other constitute an essential difference, for, "A group is a social entity in its own right." Sager (1959), writing on combined individual and group treatment, states that the introduction of group psychotherapy does not taint or interfere with individual psychoanalysis. He sees individual psychoanalysis as stressing introspective processes and eliciting unconscious attitudes, feelings, and fantasies, while group psychotherapy stresses current relationships; the patient is less regressed and functions with more ego available. Wolf and Schwartz (1962) say psychoanalytic treatment can be accomplished in group psychotherapy if the therapist focuses on treating the individual and not on treating the group. These authors remark that they avoid the use of individual therapy on a routine basis when they feel patients are using this as a form of resistance, but they make no absolute formulation in this regard. In a recent paper, Schecter (1959) opines that too early introduction of group psychotherapy into a course of psychoanalytic treatment obstructs the development and resolution of infantile transference and that three or four weekly sessions for a period of two years in individual psychoanalysis are needed to work through the oral phase of development. He sees group psychotherapy as focusing on sibling rivalry at a higher developmental level requiring greater ego strength. The rivalry for the therapist-parent's approval in group psychotherapy, in his view, inhibits and represses the expression of infantile oral cravings. The thesis of this paper is that the experience of psychotherapy in a group recalls more vividly to the unconscious the earliest feelings of oral deprivation and the frustration of the gratification of basic needs associated with survival.

The productions of patients in psychotherapy, verbal and nonverbal,

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are influenced greatly by the therapist's orientation, his unresolved neurotic conflicts, and his predisposition toward particular evidence or data. Just as in the content of dreams and in the nature of other material expressed in individual treatment the patient delivers material designed to please the psychotherapist, this same phenomenon is also present in group treatment. Thus, group therapists who stress themes, social values, and group dynamics will get, respectively, thematic material, expressions of the value systems of individual members, and observations of the mechanics and dynamics of their groups. The therapist who stresses dreams will get dreams, and so on. If it is our hypothesis that oral material comes out in group sessions, we shall have no trouble in eliciting such material. We are, however, focusing on a much more basic issue than the nature of the content which is verbalized in group sessions. We are asking whether the patient in the group can be successfully treated if such treatment presupposes the regression of the patient to the earliest levels of psychosexual development. In other words, can one really do psychoanalytic treatment in group psychotherapy?

THE GROUP AS A CATALYST FOR ORAL FRUSTRATION

It is said that the presence of other people who need and who demand is the sharpest contrasting feature between group and individual psychotherapy. The individual patient has the therapist all to himself, and thus, it is supposed, can more readily gratify his oral needs, his dependency needs, and his infantile needs. Psychoanalysis focuses on the intrapsychic life of the patient, while group psychotherapy tends to focus on the here and now, the immediate interpersonal interactions of group members to each other and to the therapist.

These arguments constitute a restricted notion of group psychoanalytic psychotherapy. It is naive to claim that the patient on the couch is the one who will delve more freely into his unconscious than the patient sitting face-to-face with the therapist or with other persons in a therapeutic situation. What we are saying, or rather what we find in practice, is simply that different defenses may operate in these two different forms of psychotherapy. The analysis of resistance in group psychotherapy demands additional skills and a different technique than the analysis of resistance in individual treatment, but the reality of this fact does not preclude psychoanalytic treatment in group.

That intense resistance can and does occur in group psychotherapy is not questioned. What we wish to take issue with is the notion that this psychic phenomenon can only be successfully dealt with in individual

psychotherapy. The following illustration portrays vividly how this takes place in a group and how it can be handled analytically.

A prominent group analyst met with one of his groups at an early morning hour. This group was an open group with a core of "old" members and other members moving in and out. It had been meeting at the same hour for five years. At one point the analyst observed that this was the only group he had in treatment in which there was chronic tardiness. He decided to deal with this as a reality and suggested a later hour so that the members could arrive on time and begin as a group at the appointed hour. During the sessions in which this was being discussed, a member objected to what the analyst was doing: accommodating the group and failing to deal with the resistance. He, the member, said he did not think it mattered if he was late for a group session, but he would feel cheated if he was late for a private session with the same analyst. Another member, a woman, said she could not start talking about herself until the other members were there. She added that she felt anxious about being the first one there and being alone with the group analyst, although this feeling was not present in her regularly scheduled private sessions with the same analyst. Another woman patient had previously reacted violently to the analyst for turning away from her, when she was deeply involved in relating a dream, to greet several members as they entered the room. The first member associated to this with the thought: "If I really had my mother to myself my brothers would interrupt me; it's futile to try." Other members associated to this with the feeling that it would be too painful to have the analyst to themselves at the beginning of the session, only to have him taken away as others entered and intervened. One member expressed fear at the reaction of other members to his having the sole attention of the analyst.

What is clearly illustrated here is the fear of group members of giving in to the impulse to grasp and consume the mother therapist. The manifest content had to do with coming to sessions on time, but the latent expression was the frustration of oral gratification in the group. The varying covert expressions of rage—late-coming, withdrawal, attacks on siblings—were a frequent mode of interaction in this group. When the manifest expression of anger, the tardiness, was dealt with in terms of resistance and transference, the members were free to associate and fantasize, to relive in the present early, intense feelings of oral deprivation.

It is our observation that in a therapy group the demands for feeding and the frustrated feelings of patients are more vivid, more repetitive, and more enduring. Just as in individual analysis the greater part of treatment has to do with the resolution of the conflict around infantile dependency needs, so, too, in group treatment this area is the one which takes longest

for patients to resolve. In group treatment, however, the oral dependence is highlighted as patients attack one another for consuming group time, for making demands on the therapist, and for expressing their oral needs primitively as they vie with each other for the attention of the therapist and/or the group. We find a vivid example of this in the patient who defends himself against his or her need for mother by introjection, by becoming mother, by taking the mothering position in the group.

Elaine has been the most needy member of the group from the time she entered it. She cannot wait, she cannot be frustrated, she cannot abide seeing the therapist give to another member in any form. Just as in her family she got attention by arousing hostility, she has managed to do this in the group. She does this under the guise of giving, offering interpretations which are often perceptive but which attack and undermine the ego strength of those to whom she generously attends and devotes her insight. Then, following a session in which she has managed to have an association or identification or some response to any and all of the material which other members have presented, she complains to the therapist: "Why can't you give me something? I have given to others. Why do you deny me?" At one point, her monopoly of the group time became too much for the other members and their rejection of her was total. It was not possible to work with her in the group and she was seen individually for a few months, after which she was again seen in the group. The group members said they did not want her back, and she was told this. When she returned, she was frightened of incurring the wrath of the group and so she participated less often. She was encouraged to express her own feelings rather than make interpretations of the others' dreams and behavior. She said, at length: "In my family, I was the one who had to be told how to behave. You don't tell anyone else in the group how to behave." The therapist replied that his control over her behavior in this "family" group was a necessary frustration for her. Elaine had dramatic scenes in the group in which she called herself a pig and spoke in very primitive figures of her orality. Her ego strength increased as she went on, with some gains in frustration tolerance and insight. Other members who defended themselves differently were spotted by Elaine as being just as hungry but as taking food in a different, more palatable way than she did.

For a time, the members in this group were preoccupied with sexual material. There was considerable acting out sexually, not with one another but in their lives outside the group. Two female members in particular vied with one another for the attention of the attractive male members of the group and for the therapist. There were scenes in which these two women resorted to all but hair-pulling and scratching over who was the most

sexual, the most successful in extramarital activity, and the most desirable in the group. When these encounters were stopped by the therapist as resistance maneuvers, the two women banded together against the therapist. Then their real fantasies emerged and they vented their rage toward him as the mother. For Elaine, he was the cruel mother who preferred her sister and cut her down in the family. For Agnes, he was the mother who could never clearly choose between her and her sister and who could never give her enough. Gradually, the content of the sessions and the basic transference shifted to mother. There were, on occasion, entire sessions in which the members associated to their mothers, and considerable emotion was expressed. Group members were encouraged to relate early memories to their current conscious feelings toward the group or the therapist as a mother image or as a parental image. One member, who had for more than a year protested the inefficacy of the group and of any and all forms of psychotherapy, began to talk, for the first time, with feeling about himself and his home life.

Carl had, for the most part, focused on his strict, authoritarian father as the cause of his problems, and reacted to the therapist as a father figure who would punish him if he were free or spontaneous in the group. Members frequently commented on how much warmer and more likable Carl was at alternate sessions (those held at members' homes without the therapist) than at regular sessions. This patient needed to keep the therapist before him as a punitive superego figure to protect him from his primitive incestuous wishes and savage impulses toward his mother and siblings. As members began to face not only their anger toward their mothers but their need for the ideal mother they never had, Carl abandoned his compulsive expression of feelings of being cheated, denied, and exploited in psychotherapy and began to interact more freely with the therapist and the other group members. At this point in treatment, he was free to admit to some feelings of warmth, some positive transference to the therapist, and he grudgingly admitted that he was getting something, however insufficient.

Martha, who also had protected herself from her wish for warmth and mothering from the group and the therapist by expressions of anger and disgust toward the therapist, and whose dream material was overloaded with sexual symbolism, also made a shift. She had been overinvolved with her rejecting mother through twelve years of adulthood and marriage. The more her mother rejected her, the more she courted her. At the same time, she rejected the therapist and the group members as ungiving. She denied her need for food and mothering in the group by saying it was not there, or that if it were, it might be poison, e.g., "You couldn't trust it." It was safer for Martha to pursue the rejecting mother than to accept warmth from

those who offered it. This defense was necessary since she feared that to find the warm mother would be to be absorbed and enveloped by her. She often commented on the plants in the office, that they were not watered sufficiently, that they were dying. On one occasion she said to the therapist: "I know you can't help it if the plants don't flourish here, it's so dry and arid." The therapist related this to the psychological atmosphere, remarking that she was talking about herself and her feeling that she could not get nourishment in the group atmosphere.

One of the most vivid sessions with this group occurred in a meeting that followed a lapse of six weeks during the summer. While the therapist had handled the members' anxiety about separation in both group and individual sessions prior to his vacation, the reactions were intense and, in this session, unanimous. Interpretation of what was going on gave relief to some members, but others continued for the entire session to vie with one another to get the therapist's ear. One member later said, "How could there be anything for me, the group was picking you into little pieces."

THE THERAPEUTIC RESPONSE TO ORAL DEMANDS

The treatment goal is working through the patient's archaic feelings of deprivation and frustration currently experienced in the group setting. To facilitate the resolution of these conflicts, the appropriate therapeutic intervention is interpretation, not gratification. The answer, in terms of the treatment goal, is not to react to the needs expressed by the patients by attempting to feed them all but to respond to the ego rather than the unconscious, primitive impulses with interpretations of what members are expressing. This is not easy in group psychotherapy considering the intensity with which group members can band together to make demands on the therapist. If the therapist overextends himself to hear everyone and to answer everyone, he compounds the members' feelings of being infantilized and his own fantasy of omnipotence.

Frustration is a necessary part of psychoanalytic therapy, whether individual or group, and the well-trained analyst, like the good mother, is, hopefully, sensitive to what the patient can tolerate initially in treatment and later as his frustration tolerance and ego strength increase.

Both of the present writers see many patients in combined, concurrent individual and group treatment. This paper is not taking issue with psychoanalysis as a vital and valuable treatment modality; instead, the attempt has been to explore and delineate the possibility of working through the earliest level of regression in analytically oriented group psychotherapy. Any limitations on this, we feel, are not inherent in the medium of group therapy.

but, rather, in our development as psychotherapists. It is our conviction that oral regression can be and is experienced with emotional intensity in group therapy. The absence of any expression of oral regression or oral dependency is an indication of possible resistance and may well engender the anger and rage that every group member and human being experiences at having to share the parental figure. Tapping this resistance and dealing with it in group therapy can facilitate the resolution of the most primitive wish of all—the cannibalistic urge to introject the mother and gain all the substance of life.

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PHASES OF DEVELOPMENT IN AN ADULT THERAPY GROUP

SEYMOUR R. KAPLAN, M.D.,¹ and MELVIN ROMAN, Ph.D.¹

The purpose of this paper is to present empirical findings from observations of a closed therapy group and to discuss their relevance to group-as-a-whole phenomena, particularly the postulate of group development.

BACKGROUND

Traditionally, two frames of reference have been utilized in the study of group behavior. One focuses on the individual's subjective reactions to the group situation and his role relationships in this situation. This is essentially a two-person model, and the clinical approach has emphasized the basic emotional bond between the member and the leader. Freud (1921) noted the parallel between the member's subjective responses to the leader and the child's instinctual needs in relation to his parents. The second approaches the group as an entity in itself and views individual behavior as a reflection of an integral function in a dynamic, equilibrium-seeking social system. It is held that all groups, regardless of their purpose or task or nature of membership, pass through specific stages of development and that the group's work competence and reality testing will vary according to its phase of development (see Bales, 1950; Stock and Thelen, 1958; Bennis and Shephard, 1956; and Schutz, 1958).

As shown in Figure 1, we have organized our findings in such a way as to correlate the two orientations referred to above. The categorizing of behavior into phases has been done for purposes of study and exposition and implies a much more definitive structuring than one actually observes. Nevertheless, with this limitation in mind, we do feel that it conforms with our experience and serves well as a model of process within adult therapy groups. Figure 1 is intended as, in effect, a table-of-contents orientation to the detailed clinical material that follows. The left column of the chart outlines the structural differentiation of the system, while the three right columns schematize the "as if" character of the individual's relationship with the therapist or therapist-substitute, modeled after familiar historical role relationships. The themes associated with each phase in the group's development are also reflected in the Figure. The reference in the Figure to mythological models is intended to call attention to the influence of the

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FIGURE 1

PHASE I: THE LOOSELY ORGANIZED PSYCHOLOGICAL GROUP (Medical Model)

↓ Regression

PHASE II: THE COALESCENCE OF THE PSYCHOLOGICAL GROUP

Interaction Models

Structure

Theme

Family

Social

Mythological

A: *Patients interact as part of the group as a unit.*
(Common bond on the basis of a shared mythology)

Dependency

Student-Teacher

Disciple-Demigod

B: *Patients interact as part of a subgroup of men or women as a unit.*
(Common bond on the basis of shared sexual identity)

Power

Younger Sibling-Older Sibling

Teenager-Young Adult

Follower-Heroic Leader

C: *Patients may interact as part of a pair as a unit.*
(Common bond on the basis of complementary character traits)

Intimacy

Husband-Wife

Friends

Individual-Society

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PHASE III: THE PARTIAL DISSOLUTION OF THE PSYCHOLOGICAL GROUP

(Minimal Interaction, Individual Transference)

group situation upon the way in which the individual perceives reality. While the social and family models reflect the ways the members of the group used earlier modes of interpersonal relationships to deal with the anxieties created by the need for intimate human contact, the shared mythology seems to reflect the use of earlier patterns of thinking and of learning to deal with the tensions created by the need to interpret and give meaning to a new and unfamiliar environment.

COMPOSITION OF THE GROUP

The group initially consisted of eight patients, four male and four female. Except for one male patient who was in his early twenties, the average age was thirty-five. We will refer to them with names that characterize their initial group roles and which may help to dramatize their relationships.

Mrs. Strong had a dominating personality with an intense need to control and organize the meetings, which she expressed in her life as a leader of social groups. She was actually a confused individual with overt homosexual inclinations upon which she had never acted. Diagnostically, she was considered to have an obsessive-compulsive character disorder with evidences of decompensation. Mrs. Small was an attractive woman who tended to dress in a flashy way that was set off by her platinum blond hair. Consciously, however, she did not desire the attention she received from the other patients and her cry was, "Don't pick on me." Diagnostically, she was classified as an anxiety hysteric. Mrs. Flutter, on the other hand, seemed to say by her restless movements, "Please pick on me," although the attention flustered and confused her. She projected a fluttery, helpless quality which invited attention. She was given to obsessive-compulsive rituals and uncontrollable rages at her children. Mrs. Proper, a woman with a diagnosis of anxiety hysteria, was overly concerned with moral principles and was a behind-the-scenes manipulator. She attempted to use the group in a vengeful attack upon her husband who had been unfaithful to her. Mr. Beaver, a competitor with Mrs. Strong for domination of the meetings, had to see himself in conformity to the therapist's expectations and was unaware of his ambivalence toward authority. He was a detached, highly intellectualized person. Mr. Don's hero was Errol Flynn. He was a frustrated Don Juan encumbered by rigid moralistic views. Essentially, he was an unsophisticated man who believed in male supremacy but who suffered from premature ejaculation. He was plagued by anxieties at his work which at times he expressed in a paranoid fashion. Mr. Child, a student, the youngest member, was an ambulatory schizophrenic who had suffered

repeated failures in his studies. He acted like a helpless child who could never be satisfied with himself or others. Mr. Hermit, the isolate in the group, was a skilled laborer. He was a mild-mannered man who had suffered a reactive depression when his wife left him, taking their child with her.

It can be seen from this description that the group composition was heterogeneous in terms of the intrapsychic conflicts. However, the members were quite homogeneous insofar as moral and social attitudes were concerned, and they were at the same economic level (lower middle class). Three of the members, Mr. Don, Mrs. Proper, and Mr. Hermit were Catholic; the others were Jewish. Their moral attitudes were reflected in the anxiety that Mrs. Small had in revealing an episode of premarital intercourse with her husband, and in the censorious attitude among the other patients toward this behavior. None of the women worked and they were all conscientious about their household duties. They were all married and, with the exception of Mr. Child, all had children.

Two of the patients, Mr. Beaver and Mrs. Flutter, had received individual psychotherapy for a year in the hospital outpatient clinic. Mrs. Proper had seen a psychiatrist sporadically in private consultation. Otherwise, except for intake procedures, the patients had had no psychiatric contacts. The group sessions were held once a week for an hour and fifteen minutes. There were no individual sessions and no scheduled alternate meetings. No new members were added to the group during the period reported upon (our previous studies (Kaplan & Roman, 1961) indicated that the introduction of a new member alters the spontaneous development of a group). It was a teaching group which was observed from behind a one-way screen by psychiatric residents, each of whom took turns sitting in the treatment room.

OBSERVATIONS OF BEHAVIOR

Phase I: The Loosely Organized Psychological Group

In the first session the therapist took the initiative in a discussion of the therapeutic principles which had been outlined in individual interviews prior to the group meeting. The willingness of each member to participate in the group sessions, with minimal structuring by the therapist, had been previously ascertained. Acceptance of these principles was openly or tacitly reacknowledged by the members, and any remaining questions were answered. With this business settled, each patient set about to demonstrate how, out of inner necessity, he would attempt to circumvent the agreed-upon arrangement.

What followed, initially, was an attempt on the part of the

patients to organize the meetings according to their past experiences with physicians. They re-presented to the therapist the list of their symptoms which had been previously discussed in the preliminary interviews prior to the group meetings. At the end of the session, those patients who had been receiving medication lined up to have the therapist renew their prescriptions without in any way experiencing this activity as noteworthy for discussion. Whatever interaction occurred between the members of the group was obviously only intended to fill in, since the primary focus was a one-to-one interaction with the therapist. The members engaged in a certain amount of chatter which served to cover the ordinary social amenities and to reduce anxiety, but there was no organized group discussion at this point. The fleeting common issues that manifested themselves concerned mainly management problems of children. This was partly a reflection of one of the common interests among the members of the group, but it was also a disguised reference to their common attitudes toward the therapist.

In the third session there seemed to be a sudden burst of movement, which was reflected in a rearrangement of the seating pattern. Prior to the therapist's entrance there was a bit of mischievous play in which Mr. Child sat in the chair the therapist had occupied during the previous session. In this session, and the following several sessions, there were strong attempts to involve the therapist in personal and emotional interplay. There were tentative expressions of both hostility toward and affectionate interest in the therapist by Mrs. Flutter and Mrs. Small. However, the most dramatic expression of a patient's attempt to involve the therapist occurred in the fourth and fifth sessions when two members discussed acute situational crises, one involving the possibility of a marital break and the other the emotional breakdown of a relative. In both cases, to judge from the manner of the presentation of the situations and the group's reaction, it would have appeared that active intervention by the therapist was the only solution. Actually, in the case of the marital problem involving Mrs. Proper and her husband, it was a priest who functioned most effectively in aiding the patient. In the instance of the emotional breakdown of a relative, Mrs. Flutter knew the normal channels for hospitalization and there was actually nothing the therapist could realistically add. Nevertheless, it was evident that there was expectation on the part of the members of the group that the therapist would, of necessity, feel himself duty-bound to intervene actively. The situations were seen by these patients as requiring active intervention by a physician in the instance of a medical crisis. Yet, following the resolution of these crises, which occurred within a few days, there was no overt expression of resentment toward the therapist by either

of the two patients for his failure to accommodate the implicit expectations. However, in the seventh session, following the therapist's interpretation of the crises, Mrs. Flutter expressed her disappointment and broke down, weeping. This was the first direct personal interaction between two people in this particular group situation during the formal sessions. It had been preceded also by the first prolonged silence and intensely awkward moments of the group. In retrospect, it appears that this may have been a turning point in the course of the group's development. Nevertheless, it is interesting to note that there was already a certain tendency toward ritualization from the beginning of that session. This was manifested by the patients returning to the same seating arrangement that they had formed in the first two sessions and that they were to maintain through quite a number of sessions following, as if to document the beginning of stereotyped and ritualistic activities. Gradually, in the next few sessions, a change seemed to come over the members as though they had finally decided on a course of action. It was at this point that an observer might refer to the gathering of individuals as "a group." The patients seemed to take over for themselves, as it were. This consciousness of being a group was demonstrated by expressions of awareness on the part of the patients of "outgroup" versus "ingroup" boundaries. This, perhaps, was accentuated by the presence of observers and the one-way screen.

In retrospect, it appears to us that a great deal of what was later to become the conscious concern of the group was already manifest in the first seven sessions. For example, the formation of subgroups was demonstrated by the primary seating pattern which consisted of the men lining up on one side of the room and the women on the other, with the exception of Mrs. Small who sat among the men. Furthermore, the future roles that were to be specific to the evolving dramas in the group were already partly delineated. Also, those patients who were to verbalize affinities or dislikes for each other and who were to become the focus, to some extent, as pairs, already gave some evidence of their preferences. In this sense, these early sessions seemed to compare with the openness of the first dream that a patient will give in individual therapy.

In terms of the personal reactions of the individual patients, it appeared that all of them were experiencing feelings of inferiority, or manifesting attempts to compensate for this reaction. There was a tendency of all the members to project blame upon their spouses or upon environmental circumstances to account for their unhappy life situation. Were it not that this occurred in the framework of the group situation, one would be inclined to say that there was a marked paranoid trend in all the patients. In terms of the compensating reactions, Mr. Don and Mr. Child had a flight

into health in which they proclaimed their superiority over the more overtly conflicted members, particularly Mrs. Flutter and Mrs. Small. Mrs. Proper began to develop feelings of jealousy and a need to control her husband. Mrs. Strong became more controlling during the sessions. Mr. Beaver found it necessary to boast about his sexual behavior. There appeared to be a need on the part of all the members to receive some personal evaluation, especially from the therapist, as compared to their previous interest in receiving an appraisal of their illness.

In summary, the patients' behavior during Phase I was characterized by their relating to the therapist as if they were in individual consultation with a physician for an organic medical disorder. This attitude toward the therapist provided the patients with a frame of reference based upon a familiar role relationship in our society (medical model). When the therapist did not respond in the familiar and expected manner, even in the face of crisis, his status as a physician seemed to take on added qualities for the patients, who began to express a need for personal evaluation from the therapist. This appeared to indicate common concern about dependent gratification.

Phase II: The Coalescence of the Psychological Group

A. *The Group as a Unit.* 1. *Therapist continues as the overt focus of group attention.* The interest in evaluation and direction from the therapist which became so intense during the second and third months continued for a number of sessions. However, a change occurred. Whereas in the first few sessions each patient seemed to be asking the therapist as a physician for suggestions about his own personal needs, the implicit communication later changed to: "What can you suggest for *us*?" or "What can *we* do?" This seemed to reflect a reorientation from personal treatment with a doctor to a concern with group action. It represented a request for structure and for guidance in a course of action, which the members apparently felt they needed. Some of the questions addressed to the therapist at this point, involving concern with procedure, also implied some anxiety about the duration of therapy. The members wanted to know when they would be able to tell that they were cured and how long the group meetings would last. They also seemed to be evaluating the pros and cons of group versus individual therapy. In part, the therapist's central role was viewed as a continuation of the enactment of the medical model, although reference to him as a teacher and to the group situation as a classroom was also made. In part, however, the implicit atmosphere of the group interaction seemed to convey a deifying attitude toward the therapist. There was a sense of

urgency on the part of the patients as if to imply that the therapist had "the answer" and that he was withholding something precious which could magically cure them. It was not possible to disabuse the patients of this perception of the treatment process, and indeed any attempt to do so only reinforced their convictions. The patients' childlike attitudes were sometimes directly apparent in their efforts to please the therapist and to elicit a favorable evaluation from him.

Coincident with heightened preoccupation with the therapist, there was a great deal of activity occurring among the members after the formal sessions. There were coffee klatches, car rides home, bathroom meetings, all of which seemed to involve a great deal of enthusiastic interest on the part of the members. Initially, the members did not talk about these contacts even though there had been a mention by the therapist that, in the event of such contacts, they should be considered as relevant to the group sessions. It did not seem to occur to them that any of these contacts were in any way related to their therapy and they avoided discussion of them just as they had avoided discussion of their requests for prescriptions.

On the whole, the members revealed more of themselves to each other in these informal meetings, both through the nature of their actions and the sharing of secrets, than they did during the formal sessions. Although these meetings appeared casual, and even accidental, depending on the way members traveled to and from the clinic, it became evident that there was an intense emotional investment in these contacts.

The atmosphere during the formal meetings was quite enthusiastic, attendance was good, there were no overt expressions of hostility or disappointment toward the therapist.

In summary, the transition to Phase II was characterized by a coalescence of the patients into a psychological unit based originally upon the medical model but later reinforced by a common conviction of the resources of the therapist to cure magically. The patients interacted as a unit and related to the therapist as a superior, and, indeed, godlike person. This perception became the guiding principle in the behavior of the group. The dependent needs of the patients were expressed not only by direct requests for advice or attention by some patients but by a common consensus that the reality of the group situation was more closely akin to a mythological construct than to a painstaking process of change over a period of time.

2. *Patients eventually begin to emerge as the overt focus of group attention.* It gradually evolved from the primary organization of the group around the leader that some patients began to substitute in the leader role in response to a continuing need for direction on the part of the other patients. They still were searching for "the answer," but there was a will-

ingness now to accept this from a fellow member. Although what was enacted was essentially a leader-follower orientation, it continued to be modeled upon the members' experiences with physicians. One or more patients acted as "the patient" while others advised or analyzed his problem, functioning in the role of "the doctor"; still others sat by silently. Mrs. Strong, Mr. Beaver, and Mr. Don acted for the most part in the dominant roles and the other patients, in a more compliant manner, except for Mr. Hermit who did not appear to be too involved. Regardless of content, the attitudes expressed were accusatory either toward spouses or themselves. The analysis and advice given were only thinly veiled judgments. Although one member would say that another patient was disturbed or that his spouse was sick and needed treatment, the communication was really a value judgment rather than a psychiatric appraisal. The judging person was saying, "You are sick," and the implication was, "I am better than you," or "You are better than your spouse." In response to this, some members adopted a confessional manner, revealing hidden secret shames. It appeared that there was a continuing need for evaluation (as was evident with the beginning of the coalescence of group psychological processes) but now "the group," rather than the therapist alone, was seen as a resource for evaluation. Despite the judgmental atmosphere, all the members seemed to derive support from the sessions and reported some symptomatic relief. On the whole, there was a strong feeling of mutuality and esprit de corps. It did not really seem to matter to a member whether he was overvalued or devalued. This observation was confirmed in later sessions when the confessions and judgments were reviewed and had apparently been forgotten as though stricken from the record. What seemed to be important to the patient was the belief that he and the rest of the group were doing something important and that, thus, the importance attributed to the meetings was justified.

On the whole, the sessions could be called group-centered, with the therapist receding from the direct focus of interaction. There was some bickering, especially between Mrs. Small and Mr. Beaver, who were the primary protagonists for the dominant roles in the group. Mr. Beaver would often remind the group of the therapist's suggestions about the importance of nonjudgmental attitudes and the need for free expression of thoughts and feelings. However, the other patients seemed to realize that he was doing this in order to assert his control over the sessions and particularly over Mrs. Strong, who reminded him of his wife. The postgroup activities continued in full force and were still kept isolated from the sessions.

In summary, in this part of Phase II the patients continued to interact as a unit but with a change of focus from the therapist as the magical agent

of cure to a substitute from among the group membership. There was no essential change in the perception of the treatment process. However, the group began to reflect the personalities of its members in the style with which the group allocated the dominant role functions. Although each therapy group appears to develop similarly in structure, thematic concerns, and utilization of familiar role relationships, each group varies in the manner in which it deals with its integral functions, and in this sense develops an identity of its own (Arsenian, et al., 1962). While interest in gratification of dependent needs by the therapist persisted, the patients did not manifest this need as openly as in the early sessions.

B. The Subgroups. Toward the end of the first year of meetings, and after a period of adjustment following summer vacation, another gradual change seemed to come over the group. The patients were more sincere in their reactions. While there was still a tendency for adoption of a confessional attitude, it had less of an evasive quality. The remarks of one patient, particularly when of a sexual nature, would be followed by similar revelations by other patients, sometimes in a "going around" fashion. Although moral and value judgments continued, on the whole there was a lessening of censorious attitudes. This appeared to be coincident with heightened awareness of sexual identity in the group, so much so that there very often appeared to be a subgrouping of males and females. While this had been evident at the beginning of the meetings, it began to be expressed in the nature of the patients' communications. Whereas previously there had been concerns for evaluation by the therapist and then later by the group, now the evaluation sought seemed to be: "What do you (the subgroup) think of me as a man (or woman)?" Discussions during this period often dealt with sexual experimentation, including discussions about masturbation. These discussions were of the act of masturbation; very rarely were masturbation fantasies revealed. When masturbation was discussed, it was often associated with memories of traumatic adolescent experiences in which a restrictive parent was involved. About this time the patients began to discuss the events that had been occurring in the postgroup meetings. At first, it amounted to "telling tales" on one patient by another, but gradually there was more open discussion of these events and their implicit meaning for the patients. In particular, they discussed the flirtations engaged in during postgroup meetings.

At this time there was considerable emphasis on fears about loss of control over anger. Mr. Hermit, who had been the isolate, expressed a murderous rage toward his brother-in-law. This crisis in the group was similar to that which had occurred in the earlier sessions, and at that time

also it coincided with an increase in restlessness and action on the part of the members, one manifestation of which was the changing of seating patterns. The patients were quite concerned that Mr. Hermit would actually act upon his impulses and they responded to the emergency with attempts to mollify him and to induce him to be reasonable. As in the past, there was an implicit expectation that the therapist would actively intervene. However, as the therapist anticipated, the patient was actually able to contain his anger and utilize the experience constructively, and this sufficed to alleviate his reactive depression and resulted in partial remission of his symptoms.

While there was some open curiosity about one another, for the most part this was avoided, especially when there was talk of sexual experimentation. As if to document the division of male and female, Mr. Beaver often provided a focus for hostility by blatantly declaring his belief in male supremacy and a double standard. At such times the women would join together in their ridicule of him. This cliquishness of the women was also observable at other times, and occasionally the atmosphere was that of a "tea party," with the men sitting restlessly in attendance. This feeling of mutuality was never as prominent among the men, although on occasion something in the nature of a "bull session" prevailed. At times, there was a rivalry between the sexes somewhat reminiscent of the provocative behavior that develops between groups of adolescent boys and girls. It was apparent that these reactions indicated an important undercurrent of the emotional attitudes of the patients.

Coincident with the subgroup formations were more open acknowledgments of strong feelings between two members of the same sex, indications of which had been evident among the women, especially between Mrs. Strong and Mrs. Small, who rode home together in Mrs. Strong's car. It seemed that Mr. Child had a similar affinity for Mr. Don, in whose car he rode, usually with Mrs. Flutter and Mrs. Proper. However, these feelings were never freely elucidated since both these men left the *group* shortly after these reactions came under discussion. Mr. Child's departure was the result of his leaving town, and Mr. Don claimed that his work schedule made it impossible for him to continue (the meetings were held during the morning).

There were significant intrapsychic reactions among the patients during this phase. Mrs. Strong, who had previously felt quite alienated from and hostile toward her husband, had a renewed sense of closeness and fulfillment in her marriage. The anxiety and conversion reactions of Mrs. Small and Mrs. Proper diminished, along with a general decrease in their sexual inhibitions. Mr. Don, prior to his departure, remarked upon his

increasing ease and confidence with his fellow workers. Mr. Beaver, who had trouble staying on a job, started to work with regularity and efficiency.

There were some overt expressions of hostility toward the therapist, along with increased curiosity about his personal life. On the whole, this seemed to reflect a new trend away from the previous emphasis on a magical leader to the concept of an idealized male figure. It was also possible to note that the group seemed to feel somewhat similarly about the capacities of its own members. For example, Mrs. Small was seen as an ideal example of femininity and Mr. Don as the male hero. Curiously enough, Mr. Don was able to dramatize this role by an actual heroic act which received recognition in the newspapers at that time. It seems likely that his departure from the group was related to his need to maintain this role (in absentia) and to avoid the trend of the sessions which began to focus upon the pairing relationships.

In summary, during part B of the second phase, alteration in the structure of the group occurred, with each group member interacting as part of a subgroup of men or women. However, some degree of group cohesion and esprit de corps was maintained and was probably necessary for the overt awareness of sexual differentiation. The expectancy for a magical cure from a deified leader diminished and was replaced by an apparent search for identification with an idealized hero of the same sex. The role relationships seemed modeled upon the younger-older sibling relationship or its later manifestation in the younger adolescent's hero-worship of an older teenager. Resistance to change persisted not only in the preoccupation with external (rather than internal) events but in the continuation of codified behavior now based on the notion of hero-worship. Dependency themes were less in evidence and there was more direct concern with the power of authority, especially in the face of defiant and assertive behavior. Some awareness of the concern with intimacy began to appear. From the point of view of its development, the group seemed to allow for greater differentiation and a higher level of individual autonomy, albeit the roles were still controlled and stereotyped.

C. *The Pairs.* The manifestations of this phase occurred toward the end of the second year, approximately between the sixtieth and eightieth sessions. Two members of the group seemed to be the focus of the attention of the other members and a psychological group coalesced about them. The two members interacted in such a way as to operate as a pair, and by the interaction, they reinforced defenses against the unconscious significance for each other of their relationship. Apparently it was not until psychological group formation had diminished sufficiently that the importance of

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the pairing could be acknowledged and dealt with as having emotional significance.

From the point of view of the group situation, the pairing reactions provided a vicarious sense of intimacy which all the patients shared, to a degree, with the paired members. In the instance of Mr. Beaver and Mrs. Small, they documented their relationship by maintaining a seating arrangement with their chairs a little closer together than the others and by placing the one small table in the room between them. Upon the table they placed one pack of cigarettes (usually provided by Mrs. Small), which they would share. At times the other patients would be grouped about this couple as if "watching two goldfish in a bowl," to quote one of their associations. This coupling reinforced Mrs. Small's role as a coquette and added to Mr. Beaver's masculine status. The compulsive aspect of this interaction became apparent whenever they spoke of separating, the thought of which would create intense anxiety in each of them. Patients with a strong affinity or dislike for members of the opposite sex, particularly if their interaction was such as to identify them as a pair, often noted that the relationship was very similar to marital interaction.

The pairing between patients of the same sex seemed to have a more profound personal aspect and less of group focus. As a group development, it seemed to reflect an idealized friendship, such as exists between adolescent "chums," and appeared to emerge coincidentally with subgroup cohesion between the sexes. As noted, this was most obvious among the women, less so among the men. It was difficult for patients who participated in the pairing to discuss their reactions. The manner in which other group members helped to elucidate pairing relationships is indicated in the following example.

Mrs. Strong, who was experiencing a great need to deny her concern about her femininity, kept looking at Mrs. Small, who had evolved as the ideal feminine representative in the group. She was not conscious of her attention to Mrs. Small when she spoke. When Mr. Beaver pointed out this particular nonverbal interplay, which the therapist could not see because of his seating position, it enabled Mrs. Small to give some relevant associations to this subtle interaction.

This brief example demonstrates one of the constructive aspects of the group situation, since it is likely that Mrs. Small would not have been able to speak as freely without Mr. Beaver's observations. However, this is not to say that it was without its defensive aspects, since Mr. Beaver did not, and presumably could not, reflect on the reasons for his interest in the

particular by-play between the women. Nevertheless, his participation was quite different from the purely defensive maneuvering of his role-playing in earlier sessions, when his comments usually reflected his role as a doctor's assistant.

At this point, a very important but subtle change was occurring in the alignments within the group. The patients who previously had initiated conversation in the group became more and more reluctant to speak openly. It was the more submissive and retiring patients who now began to initiate change. For example, it was Mrs. Small and Mrs. Flutter, whose repressed conflicts appeared to be coming more to the surface, who began to make the most relevant and spontaneous associations to their interactions as reflected in their personal reactions toward other members and the therapist. There were significant changes in symptomatic reactions at this time. Mrs. Strong began to experience increased difficulties with her husband, again coincident with the growth and development of her submissive partner, Mrs. Small. Mrs. Small, on the other hand, whose relationships with her husband had been improving and whose anxiety symptoms had diminished outside the group, began to experience a conversion reaction only during the group sessions (she developed a choking sensation, especially when Mrs. Strong was talking). Mr. Beaver had an unusual period of temporary impotence coincident with some of these implicit changes occurring in the group. It became clearer now that those patients in the group, such as Mrs. Strong and Mr. Beaver, who had been dominant insofar as initiating conversation and playing the role of leaders but who were also the most detached, found increasing difficulty in the verbalization of their personal reactions toward one another. The content of these reactions dealt now, more clearly, with feelings of jealousy and rivalry, particularly as they related to feelings about the therapist.

At this time there were some dreams mentioned which appeared to be direct representations of the group. The manifest content of the dreams often revealed the preconscious or implicit communication in the group.

In summary, in part C of Phase II, group structure was sufficiently flexible to allow overt attention to and discussion of the pairing relationships. The pairing relationships appeared to be the most complex structures in the group, since they were both an expression of the development of the group as a whole and closer to the unique aspects of the individuals involved. Insofar as the group development was concerned, it seemed to be an expression of a search for cure through intimate contact with another group member as compared to the blind obedience or the idealized identifications of the earlier group relationships. Nevertheless, it appeared that the

pairing relationships were essentially based upon complementary character traits in which narcissistic elements predominated.

Phase III: The Partial Dissolution of the Psychological Group

With increasing tolerance for personal reactions and for fantasy elaboration concerning interaction with other patients, thoughts and feelings about the therapist were verbalized more frequently. We do not mean to imply that increased attention to the therapist during the third year meant that the patients had been unaware of his presence during the group-centered phase of the interactions. Through glances and innuendo, the patients acknowledged his presence, but their spontaneous verbal reactions for the most part were directed toward other patients. When spoken to directly the therapist was asked questions about administrative functions or technical issues, indicating that the patients persisted to some degree in relating to him in his role as "a doctor." Although there was hostility over administrative issues (i.e., rules about registration, vacation), the patients were unable to see this as related to their feelings about the therapist.

It eventually became possible for some patients, in accordance with the severity of their illness, to deal directly with their anxiety about the therapist as an individual toward whom they experienced emotional reactions other than those relevant to his realistic functions. The following is an excerpt from the eighty-sixth session which characterizes the nature of these interactions.

Mrs. Small and Mrs. Strong found themselves alone in the therapy room prior to the session. Instead of the chatty informality which, in earlier group meetings, characterized these pre-session discussions, they were unaccountably embarrassed and awkward. When the therapist entered the room the embarrassment subsided. Neither of them mentioned this reaction at first in the group session, although it was the most pressing experience on their minds. Rather, Mrs. Strong typically initiated the conversation of the group, telling the group that she had experienced a sense of unreality during the last group session when the other members had laughed at her. It reminded her of similar feelings at the age of five when she also unwittingly had provoked the laughter of her mother and aunt. Both events involved a capricious attempt on the part of Mrs. Strong to embarrass another female, although the patient was unaware of this and actually felt bewildered. When her discussion failed to engage the group, she returned to her predominant theme, blaming her husband for her dissatisfaction in life and proclaiming her latent talents for being a superior woman. Mrs. Flutter followed her with criticisms of her own husband, but following description by Mr. Beaver of his tender concern for his wife, this subsided. Mrs. Strong

noted her increased awareness of a need for the group but wondered why she had shifted her chair, which she realized after the therapist entered took her further away from him. She then commented upon the awkwardness she felt with Mrs. Small in the pre-session contact. During the early part of the session, while Mrs. Strong dominated the conversation, Mrs. Small was restlessly moving in her chair and clearing her throat. In discussing their awkwardness, both women felt that the attention given to their relationship by the group contributed to their discomfort. Mrs. Strong, however, could not enlarge upon this and at that moment felt detached about the recollection. However, Mrs. Small was aware of a continuing anxiety and said that she felt that she had a conflict of loyalties between Mrs. Strong and the therapist, which she was re-experiencing at the moment. Her associations led at first to an analogy of a similar conflict with her parents, but the intensity of these feelings related to an encounter with her personal physician. She cried convulsively with the recollection of his propositions and his fondling her when she was 15 years of age, and described the conflict of desire and guilt. At this point, Mrs. Strong, in a very detached way, intellectualized about her reactions and, in an increasingly compulsive manner, seemed unable to stop her talking. When Mrs. Small again spoke, she said she felt cheap and stupid about her reactions, noting how she was still influenced by her mother's values. She had become more aware of her need to dress in a manner to gain attention, and she felt fearful of the intensity of her wishes to be noticed by the men in the group. She wondered if she were oversexed and said she felt like a freak. She was unclear as to whether she was mistrustful of men, the doctor specifically, or her own ability to control herself.

While to some extent one can see a similarity to individual therapy in the nature of the transferences that were unfolding, there were some significant differences which we will elaborate upon in future publications. These differences not only influenced the evaluation of the emotional aspects of these reactions but also determined the direction of the therapeutic possibilities in this group situation.

In summary, Phase III was characterized by a further dissolution of the psychological group. Consequently, then, individual transference reactions could be experienced and verbalized. It was possible to interpret some aspects of the patients' instinctual conflicts, particularly in relation to the therapist. However, this would only be for limited periods of time, with a constant fluctuation between this and the previous group patterns. It is unlikely that any collection of individuals can relate in any meaningful way over a period of time without the structure and organization inherent in the group situation imposing a significant limitation upon the free flow of consciousness unique to the individual.

SUMMARY

In the foregoing we have presented a phenomenology of group behavior in order to demonstrate how a collection of strangers organized themselves into a psychological group. We have attempted to draw attention to the two frames of reference currently utilized in the study of group psychology. On the one hand, we have focused upon the subjective reactions of the individual member, with special reference to the role relationship to the therapist or a substitute for him. On the other hand, we have focused upon the group as a dynamic system and observed its development from a relatively loosely organized state in which role differentiation was nonspecific to one in which a greater degree of differentiation became tolerable. It is our hypothesis that the therapy group, as any small group, goes through specific phases as it develops from the undifferentiated to the differentiated condition. Each phase brings with it a specific theme or conflict, a specific interaction pattern, a specific perceptual framework. All the members to some degree participate in this development. Each phase is dependent on the resolution of the previous phases, which is experienced as a developmental crisis by the group. This has been outlined in Figure 1.

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USE OF FANTASY FOR A BREAKTHROUGH IN PSYCHOTHERAPY GROUPS OF HARD-TO-REACH DELINQUENT BOYS

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This is a report on a technique which the author has been applying successfully for several years to stimulate a breakthrough in the wall of silent seclusion with which, in group psychotherapy, hard-to-reach delinquents so often surround themselves.

THEORETICAL CONSIDERATIONS

What the delinquent feels to be the reality of life is so rejected by him, the bleak hopelessness of that reality is so fully ascribed to "others," that the mere prospect of talking about it evokes in him an amount of hostility which militates against any real involvement in the psychotherapeutic process. It is the fear of having to face reality, not the so-often repeated platitude of "resistance to authority," which forms the most reasonable, and therefore the hardest to overcome, source of resistance in the delinquent. In fact, authority is exactly that part of reality which many of them can handle with the most ease, as witness the familiar figure of the incarcerated delinquent, often with the most severe sociopathic traits, who soon succeeds in coming to terms with the authority of the administration, who is quickly buddy-buddy with the toughest guard or administrative supervisor, only to continue delinquency after release.

A separate paper on delinquency and reality is in preparation; here, it is sufficient to point out that the need to avoid facing reality constitutes a most essential part of the wall behind which delinquents take cover when they perceive any endeavor to roll back the frontier of the darkness in which they dwell. From this premise, it follows that attempts to reach the delinquent by way of reality—the approach most often used—are, and are bound to be, opposed by his conscious and unconscious rejection of reality itself, by his deep-rooted resistance to entering a world in which he feels inadequate and lost, and by his fear of a loss of status among his peers through even the mere acknowledgment of the reality of a world against which he rebels.

Because his inner world of fantasy is not as forlorn to the delinquent as hard-hitting reality, it was postulated that fantasy might be a logical alter-

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native means of approach in the therapy of the delinquent. It was realized, however, that effective use of this means would depend on two factors: the ability to involve in the therapeutic process an area of fantasy which was not too taboo and the ability to dissipate fears of having one's fantasies not taken seriously or even of having them laughed at. The question then became: what area of fantasy to choose and how to introduce the subject in the least frightening way.

Fantasy, of course, embraces an entire world of fears, needs, and need fulfillments. Condor (1957) stresses that, even in young children, access is particularly closely guarded to those parts of fantasy which deal with secret fears and anxieties. Yet, many a therapist will, after an initial period of "feeling out," reach for one of the obvious fears of a group member in an attempt to use it as a possible entrance to work at a deeper level. Withdrawal behind a stone wall usually follows such an endeavor to discuss secret fears and anxieties.

In contrast to fantasies of fears and anxieties, the fantasy pattern of heroic deeds is much less resistant to access. In fact, searching for such possible entrance by fantasy of achievements of the superman variety, we often find a well-trodden path. To boast of his wishful heroic achievements and triumphs over his own insecurity is not new to many a delinquent youngster. This path into the fantasy land is loaded with symbolic meaning and leads back deeply into fantasies of earlier childhood.

However, we have to consider a special situation when we think of utilizing such hero fantasies for access to the delinquent's fantasy life. His hero fantasies tend to contain elements of illegal behavior. They are, like the rest of his fantasy life, so pervaded by aggression that they are not likely to be shared, particularly not with an adult psychotherapist whom the young delinquent, as a rule, experiences as one of those who are representative of and responsible for his barren and suppressive world. Also, the young delinquent's adjustment to reality is so deficient that he is bound to seek in fantasy a relatively large part of his need satisfaction. His trains of imagery are, therefore, a most meaningful part of his psychological field and thus especially resistant to revelation. In addition, the delinquent's over-all rejection of reality makes him feel guilty about fantasy, and this, together with the usually weak ego formation, makes him fear rejection and ridicule as a consequence of granting entrance to his "forbidden" fantasy life.

There is, however, one realm of hero fantasy life the expression of which is not taboo. In fact, the prevailing mores encourage both such fantasy and its expression; and the delinquent culture does not oppose it. Such fantasy is that of *desires for occupational achievement*. If a delin-

quent, being asked what he would like to become occupationally, says, "a pilot," or "a doctor," or "a guy who has loads of money and does not have to work too hard," he has clearly broached a hero fantasy, for such vocational aims fall much more into the boastful hero fantasy category than into one of realistic planning.

Therefore, because they are most accessible, we decided to attempt to use hero fantasies of vocational desires as a wedge for breaking through the walls by which delinquents prevent access to anything of real personal relevance. The fact that this wedge is itself of a fantasy character provided the hope that fantasizing altogether, first in related and later in less related areas, would thus be made easier.

Children notoriously express their fantasies easiest in play, and we felt that what was true with children should work just as well with our largely immature teen-agers and even with young adult delinquents. In fact, it seemed that playful introduction of the expression of fantasy might fit the delinquent particularly well as it would bypass intellectual involvement and statements for which the individual would feel responsible. However, play, of course, may be offensive to a teen-ager or young adult because it is too "childish." We had, therefore, to evolve a technique which was not too obviously play, yet playful enough to facilitate expression. Thus, in summary, the technique we applied tried to achieve access to fantasy life by eliciting hero fantasies in the form of vocational planning and by doing this in a playful way.

A TECHNIQUE

The technique related below was first tried (1951-1953) at the United States Disciplinary Barracks, Fort Leavenworth, Kansas, in the psychotherapy of young adult delinquent soldiers (20 to 30 years old); later, 1952 to 1955, also with upper teen-age delinquents. Between 1955 and 1958, the technique was employed at the United States Army Hospital in Munich, Germany, in the treatment of teen-age sons of U. S. military personnel, who had been referred by school authorities as "predelinquent," most of whom, however, had engaged in actual delinquency (Perl, 1958). Since 1958, the technique has been used at the Government of the District of Columbia Children's Center in Laurel, Maryland, in the treatment of delinquent boys between 15 and 17 years of age.

The method underwent a good number of changes as different facets were tried and were accepted or rejected, depending on whether they were found to further or not to further the aim of achieving a breakthrough. Besides the general principles of group psychotherapy, the following specific elements were found to be of essential importance.

1. The decision as to what degree the therapist himself, as a component of the group, would participate in the process of truly revealing parts of his fantasy life. This problem, which involved the delicate area of transference, was found to be of major importance and will be discussed below in more detail.

2. Selection of the group member most suitable to start with the discussion of "vocational aims."

3. The seating arrangement in regard to the group member so selected and the relative seating of the therapist in the circle.

4. The timing of the attack.

We will not, point by point, describe these principles but instead depict them by relating an actual session.

The group was quite characteristic of those usually in treatment at juvenile institutions. It consisted of seven boys aged 15 to 17. All of them had been committed to the Children's Center of the Government of the District of Columbia at Laurel, Maryland, after the D. C. Juvenile Court had found them involved in more than one delinquency. All of these boys had proved, in their respective cottages, extremely hostile, aggressive, and almost unmanageable. Diagnostically, they were considered to be suffering from personality trait disturbances of the dyssocial type, with additional pathology present in some of the boys (mildly neurotic and/or schizoid features). Intelligence ranged from top dull normal to upper average. Enrollment in the group was voluntary. However, the boys had accepted the suggestion of a gentlemen's agreement: that if one wanted to leave, he had to come and give the group his reasons, and then he had to come once more "to give him and the group a chance to change his mind." The use of a cotherapist was found to be not essential but generally favoring the technique; and in the described group, Mr. Stewart Pennington was the author's cotherapist.

After the first session of nearly complete silence, the next five meetings were used almost entirely to vent complaints against the institution and to proclaim animosity against its personnel and policies. During these first six sessions, the therapist purposely made no attempt to change this so-familiar pattern of "gripe" therapy, so that the group might appreciate such an attempt later on. At the seventh meeting, one could feel that the boys themselves were bored with these steady repetitions and that they were wondering whether this was really all they could expect. By now they were ready to follow a cue from the therapist who, so far, had ostentatiously refrained from the expected role of a dispenser of advice and suggestions.

One boy appeared at least relatively more ready to go into meaningful material. He was, however, not chosen to be our "first man" because he was

seated between two consistently sullen and unresponsive members. The technique involved "going around," and continuation would thus have been halted and the attempt at penetration quite likely brought to an end. Instead, we decided on another boy as the target of our initial attack. He appeared not quite as ready but held higher status among his peers. Moreover, he sat regularly beside a boy whom we could expect to follow his example.

The timing has, of course, to be decided in accordance with the therapist's own observations of the specific group. Too early an attack might mean no response, while too late might mean encountering a, by then, too well-entrenched pattern of evasion. In this group, the opening occurred in the seventh session, rather late when compared with like experiences. The boy who had been selected previously to be the first target had just announced quite unrealistic expectations of early release. The cotherapist asked what the boy wanted to do afterwards. "Join the Air Force" was the answer. The author (T), asked, "Want to make it a career?" Patient (P): "No, just for three or four years," an answer quite in line with the lack of planning usually encountered among delinquents. That two remarks had been made in succession by the so far rather passive therapists charged a dull atmosphere with some degree of expectation.

T: Any idea of the occupation you want to follow?

P: (after some hesitation) Mechanic, I guess.

T: Certainly, the group would be interested to hear whether this is what you always wanted to be, or did you at some time have other wishes?

P: (laughing sheepishly) Other wishes too.

T: You feel that to be a mechanic is what you probably could achieve but there are other wishes, too.

P: Yes.

T: But these wishes seem beyond your reach now.

P: Yes.

T: Any reason why you feel they are probably beyond your reach?

P: (after some hesitation) Well, education, I guess, and money.

This was as far as one could go with this boy at this point. While he did not say much, he had—as the first one—responded to a question with a really meaningful answer. The light was, therefore, turned on his neighbor.

T: Well, Jack just told us that he had all kinds of wishes as to what he would like to do and certainly we all have wishes about that. I am not excluded. Jack has spoken; now let's go on with Bob and around the circle like in a kind of game. Everybody, including my-

self and Mr. Pennington, tells the group what he really would like to be doing—let's say ten years from now—no difference whether we think it is possible or not, just as if we would tell wishes to a good fairy who can make them come true. Jack has made the start. If it is okay with the other fellows and with you, Mr. Pennington (cotherapist nods approval), let us go around the circle and if Jack wants to add something at the end, he can do it. How do you feel about it, Jack?

Jack, whose turn was not to come again until everybody else had spoken, and who also sensed the opportunity of a deeper experience, agreed with the therapist. Bob, the next in line, a follower anyhow, the more so as Jack had status, became inspired by the rising feeling of expectation. He reported with ease that he wanted to have a business one day, "a store which sells high-class men's clothing."

Once fantasy is involved, it is amazingly easy to expand by subtle questioning into other than mere vocational areas. Questions of "And how would you like to spend your spare time if you had all that money?" or, "And would you like to be married?" and, once the procedure is running well in the circle, even questions like, "Would you like to share some of it with some relative or other person?" were answered not just in the usual monosyllabic way but sometimes in elaborate detail. From the other boys short but meaningful sentences were elicited. The group was fast alerted that another tune was being played than in the first meetings, and the form of a game made it easier for the members to come out of their shells because they did not have to accept full responsibility for what they had to say. One boy stated that he wanted to live in a lighthouse on the coast of Alaska to see the sea all day long and hear its noise, quite an accomplishment in terms of communication for one of his schizoid features. A discussion about what people and their company mean ensued before it was the next boy's turn. One of the members even dared to announce his secret aim to become a teacher (he was a very poor student in school and almost a nonreader).

One session is too short to go around the whole circle, especially since it is likely that such a discussion will not start in the very early part of a meeting. Continuation is assured at the next meeting if the discussion has been halted just short of the therapist or (if there is one) the cotherapist. The two should sit well apart to keep up stimulation in between. If such timing is not possible, difficulty in talking can be largely overcome by pointing out that Jack, Bob, and Mike were able to talk about what they would like to be doing one day. In fact, Jack, Bob, and Mike, having talked themselves, may help openly. Curiosity about what the therapist will have

to say was found in many such meetings to be a strong motivation for carrying on.

In trying out various forms of the method, the therapists were first excluded from the revealing of fantasies. This was done to avoid interference with transference. However, it was found that the method just does not work if the therapist does not join in. Actually the therapist, who, as a rule, is not standing at the very beginning of an occupational career, can be quite realistic in announcing what he would like to be doing ten years hence. The deeper the discussion has gone before, the more personal the questions to the therapist are likely to be. Usually, they will concern his family and its size, what he plans for his children, how his children are making out, etc. These questions indicate that while involvement of the therapist in the "game" may interfere with transference, it certainly fosters what delinquent boys so urgently need: identification with a father figure who, without preaching to them, lets them look at a world of goals and values which has never before been brought so close to them. We felt that whatever, if anything, might be lost in terms of transference, was more than made up for by the group being welded together through the mutual exchange of reveries.

After the last boy has spoken and the circle has been closed, we are dealing with an entirely different group. The members no longer experience themselves as isolated. They have shared with their peers and with the therapist the relieving experience of breaking down the walls of insulated solitude, of daring to express, in the company of others, some of their secret wishes. They have admitted that they have fantasies and found the courage to discuss them. They have looked at each other and at the therapist not with the eyes of dog eats dog but as human beings. This mutual experience constitutes a binding element, for, as Redl (1942) states, "A powerful force for group formation is the attainment of relief in the identical way and through the same initiatory act." In more technical terms, the achievement consists in: (1) cathartic effect, (2) direct step toward possible interpretation of symbolic fantasy content, and (3) beginning of a group superego.

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FEMALE THERAPISTS IN ACTIVITY GROUP THERAPY WITH BOYS IN LATENCY

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Traditionally, activity group therapy is conducted by a therapist of the same sex as the children. However, in view of the preponderance of boys as patients in child guidance and community psychiatric clinics and the shortage of male group therapists, it was decided to experiment with female group therapists in activity groups composed of boys in latency and at the start of puberty.

Activity group therapy, as devised by Slavson (1943), is experiential, relationship treatment through the use of small groups of carefully selected children of the same sex. Classically, verbalization and interpretation of problems are kept to a minimum. The children act out their difficulties in relation to each other and to one adult, who represents benevolent authority, in a permissive group climate with very wide structural limits.

The role of the adult in such a group is to enable the child to experience a relationship in which he can obtain love, interest, help, encouragement, and, where necessary, protection. The therapist facilitates success, implicitly favors certain kinds of values and behaviors over others, and helps the members to change their perception of themselves. Control in the group is achieved primarily through the children's desire to please the therapist and also by the way in which the children are selected so that they can act as controls or stimulators for each other. Very broad limitations are set and these are presented as the requirements of the environment.

In such a setting, there is abreaction of pent-up emotion and opportunity for the expression of problems. Regression takes place but it is not specifically stimulated. The possibility of reality testing in a protected environment is a major aspect of treatment. There is modification of superego through the pressure on the individual to conform to the values which are adopted by the group but which initially emanate from the therapist. There is strengthening of the ego structure through the therapist's ability to help the child change his self-image and self-esteem by means of the therapist's confidence in him, the opportunities he creates for the child to succeed in the group, and by the accepting climate of the group in which the members are able to feel positively toward each other. The ego is also strengthened by the gradual pressure of the therapist and the group to develop impulse

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control and to deal with problems in ways which are socially acceptable. Certain kinds of defenses are supported as against others.

However, along with these functions and possibly implicit in some of them, the therapist serves as a model with which the *child can identify and*, when of the same sex, as a model for sexual identification. This last function, of course, the female therapist in a boys' group cannot truly and must not in reality fulfill. The boys relate to a female therapist as a mother substitute, as an adult authority, and possibly as a nonrelated love object. This means that the therapist does not serve as a masculine example and that the boys have to rely on each other or on males in their ordinary lives for masculine identification.

It is the purpose of this paper to consider the implications of this difference as demonstrated in three activity groups led by female therapists. We shall discuss in the light of our experience whether it is desirable to use female therapists at all in boys' groups, and if so, in which cases it makes little difference and in which it might be specially indicated or contra-indicated.

DESCRIPTION OF THE GROUPS

The three groups were conducted in two outpatient clinics. The authors acted as therapists, one leading Groups 1 and 2 and the other responsible for Group 3. Eighteen boys, with an age range of nine to eleven years at the beginning of treatment, were involved in these groups. All the mothers and several of the fathers were in individual or group treatment. All the families were white, middle-class, and lived in the suburbs of a large metropolitan center.

Group 1

This group consisted of eight boys aged nine to ten at the start of treatment. Three were anxious, phobic children; two of the three were constricted and withdrawn and the other put up a façade of bravado and aggressive behavior. One boy was extremely hostile and more competent than him-compete with a younger brother as large as and more competent than himself. One boy was passive, dependent, and depressed; his parents had very unrealistic standards for him. One was infantile, anxious, and demanding with an overprotective, smothering mother. One boy showed provocative feminine behavior in reaction to parental overemphasis on masculinity. The eighth boy was aggressively defiant, reacting to a home situation in which the father had deserted the family and the mother had developed a psychotic depression.

This was a well-balanced group which developed an active, positive therapeutic climate very quickly. Major problems dealt with were: the boys' needs to feel more likeable and more confident of themselves; sibling rivalry; the handling of anger and fear and the acceptance of mixed feelings; how to hold one's own in peer groups without getting into fights; and the difficulty of living up to parental pressure to be successful and masculine.

In this group the boys handled their conflicts around self-concept and the expression of aggression within the latency context of good social adjustment. There was none of the intense preoccupation with masculine identity and the need to prove maleness through very aggressive behavior so typically seen in puberty. Rather, the boys explored the differences between boys and girls as children, not as men and women, and concentrated on developing their capacities to identify with each other and to grow closer to their fathers.

In almost all essentials, this group did not differ from other successful activity groups led by a therapist of the same sex. There was more verbalization and discussion of problems than in some activity groups but this can probably be accounted for by the number of highly intelligent boys (five had I.Q.'s of over 120) who came from very articulate homes.

The major difference was that the boys were very careful to keep the therapist in a culturally feminine role (and this was typical of all three groups). For example, while they did accept her help in holding parts of their models together or in interpreting a plan, they would not allow her to take part in such masculine activities as baseball, even if they were short of players, although they liked her to watch from the sidelines. Throughout the life of this group the boys related to the therapist as a mother substitute and their rivalry for her was that of siblings for a parent.

All the boys in this group responded well to treatment with the exception of one constricted, phobic boy, whose mother withdrew him when he began to become more active.

Group 2

This group consisted of seven boys aged ten to eleven at the beginning of the year. This group, as did Group 1, met during one school year for approximately 40 sessions. Two boys were carried over from Group 1. One of these was a constricted boy who, it was felt, could use another year; the other was a withdrawn boy who, while he had given up a severe learning inhibition and become much more open and active, needed to learn to control the aggressive feelings he was now able to express.

The other members consisted of two manipulative boys confused about their sexual identification, one more feminine than the other. Both of these tried to relate to adults as another adult and both were quite fearful. There was one withdrawn, depressed boy recovering from the death of his father and one sadomasochistic boy who felt rejected, unloved, and insecure. One immature boy, initially referred for soiling, was transferred from individual treatment. He had given up being a baby but was now struggling with the problems of a boy entering puberty. While previously he had been fearful and withdrawn, he was now tackling his anxiety by being aggressive and dominating.

From the start this group was more aggressive than Group 1. The more active boys immediately became engaged in acting out the aggressive feelings they kept pent up at other times, while the more fearful children withdrew into model making. The therapist had to intervene more than is usual in activity groups, in order to stress that while it was all right to ventilate anger, it was not permissible to hurt one another.

The two most aggressive boys tended to victimize the sadomasochistic child, and it took hard work on the part of the therapist to mobilize group feeling against such bullying and to help the members begin to speculate about how they could handle their anger, jealousy, and disappointment other than by violence.

As some of the older and more precocious boys began to enter puberty and to experience bodily changes, considerable anxiety was aroused and there was a resurgence of aggressive and destructive acting out. Moreover, at this point, the quality of the relationship to the therapist seemed to change and the boys appeared to be intensely competitive for her as a love object rather than as a parental figure. They resented any suggestion of control from her as a threat to their masculinity and the acting out seemed designed to show what powerful males they were. This stage was also accompanied by a persistent desire to play with fire.

At this point, a male therapist became available and it was thought that it might be therapeutic to introduce him for a few weeks as a focus of identification and as a protection for the boys against their own impulses. The boys were told that he would be able to help them work on more interesting projects. The group was unenthusiastic about the idea of a male therapist. However, when he did arrive all the boys, with the exception of the depressed child who had lost his father and the two most aggressive leaders, accepted him positively and used him to help them in their organization of ball games, kite-flying, and carpentry.

The depressed boy did not return; we speculated that his loyalty to his father could not yet let him accept another male. The two aggressive

leaders felt they could not compete with this new, strong and firm, male figure. The boy who had originally been referred for soiling was able to accept and identify himself with the male therapist after the first session. However, the withdrawn boy who had continued from Group 1 felt the competition to be too great, seemed to relinquish his bid for masculinity, and regressed into a demanding mother-child relationship with the therapist for several weeks. However, he too gradually entered into activities with the male therapist.

Almost immediately after the introduction of the male therapist, the anxiety and overaggressive maleness faded away and the group climate became much more positive. The two therapists were cast in parental roles. The female therapist was no longer the object of competition and the male therapist provided a model with which the boys could identify. Even though the male therapist stayed in the group for only five sessions, the anxiety and aggression did not return, and the last few meetings of the year were characterized by the boys being able to relate to each other in a confident, self-assertive, but not overaggressive way.

It seemed as if the problem of how to be a man had been, at least temporarily, resolved by the introduction of a model for masculine identification at the height of the conflict. The female therapist was then seen as an appropriate object for the male therapist rather than for the boys, who began to take an interest in the girls they were meeting in school and to talk about their "girl friends." The rivalry for the love object which had split the group was no longer existent and the boys were drawn together in their identification with the male therapist.

Group 3

This group consisted of six boys aged 8.9 to ten years at commencement. The group lasted for thirteen months with approximately fifty sessions. The group consisted of one passive, infantile, dependent boy; one constricted phobic boy; one demanding, clinging boy who was the odd one out in his family; one immature boy with a dependence-independence conflict and some obsessional defenses; and two defiant aggressive boys who became the leaders in the group. One of these was a neurotic boy and the other impulsive with very poor frustration tolerance. The latter responded to any control with anxiety which was expressed in further aggression and defiance. This boy had great difficulty in establishing any relationships with adults, and when he became attached to the therapist, he became extremely jealous and demanding.

This group started explosively with much aggressive behavior and regressive messing. The balance of the group was not ideal because the

largest boys were also the most aggressive. However, as positive relationships developed with the therapist, there was some lessening in the overactivity and aggressiveness and the climate of the group became more therapeutic.

However, we again ran into the same problem as in Group 2 when the more aggressive boys in particular began to enter puberty and to experience bodily changes. There was the same overaggressive, "I am the powerful male" acting out, the intense competition for the therapist, the interest in fire-play, use of dirty words, and, in this group particularly, considerable homosexual anxiety, most noticeably expressed in talking about "queers" but with some actual body exploration by two of the boys.

In contrast to Group 2, we dealt with the problem in this group by talking with the boys about the pubertal changes and the naturalness of interest in themselves and each other as changes took place. This discussion continued sporadically over several sessions and was accompanied by a great reduction in the level of anxiety, which in turn reduced the need for aggressive acting out.

Following this, the group typically went through a phase of trying to develop more structure as a means of self-control through the election of officers, etc. (seen also in Group 2), but in turn this was relinquished as unnecessary. As the group quieted, the more inhibited boys went through a phase of aggressiveness within the security of greater group control.

At termination there was considerable group cohesion, a relaxed atmosphere, a low level of tension, anxiety, and aggression, and an ability to tolerate a fair amount of frustration.

In spite of the difficulties which these two groups made for the therapists, all the boys, with the exception of the depressed child who withdrew, showed very considerable improvement by the time the groups were terminated.

EVALUATION

In general, we were favorably impressed by the results of the use of a female therapist in activity groups composed of boys.

Infantile, dependent, passive children respond very well to a female therapist, particularly in the first year of treatment. In the beginning, they really require a warm, undemanding relationship which allays their fears and prevents arousal of their resistance to becoming involved. This type of relationship can well be provided either by a man or a woman.

In spite of past theories to the contrary, the boys who were defiantly using a feminine identification as resistance to strong parental, and particularly maternal, pressure to act as a boy and as a defense against castration

anxiety responded very well indeed to an unpressuring, accepting female group therapist. They were able to act out some of their feminine needs and experience that this could be accepted without anxiety or rejection. They could gradually admit and overcome their fears and could discuss their anger at not being accepted as they were. They were able to use the other boys as an aid in masculine identification and became freer to identify with their fathers. Thus, they did not seem to miss an adult male identification in the group. We might speculate that a female therapist was particularly appropriate because so much of their difficulty stemmed from their relationship with a destructive, castrating mother.

Very hostile, withdrawn children tend to view the whole world as indiscriminately dangerous and do not initially differentiate between male and female therapist. Their first problem is to deal with their own hostile fears and projections and to risk some contact with the outside world. As they find that they can participate without disintegration of themselves or destruction of others, their next need is to build up their self-esteem, and this can perhaps best be facilitated by a warm but unpossessive relationship with a female therapist. It is only later when they begin to tackle the problems of being a boy and a man that they are more appropriately treated by a male therapist.

A female therapist was also extremely effective with the boys who had been infantilized and weakened by maternal overprotection, although obviously such boys can also respond to the firm expectations of a male therapist. Their needs are to be accepted without anxiety or smothering hostility in the guise of overaffection and overprotection, to experience success, to learn to build up their self-esteem through holding their own and through feeling that others have confidence in them, and to have their demandingness responded to with firm acceptance rather than rejection.

There was also no problem with the anxious, constricted boys, struggling with ambivalent feelings, low self-esteem, and expectations of rejection. Their first need was to learn how to take part in the group. They then had to learn to express and handle their hostilities and ambivalences. As there was implicit permission to have mixed feelings, to be afraid and jealous, there was considerable reduction in guilt. Castration anxiety was dealt with at the level of physical fears. Some of the unconscious sexual anxiety was relieved through the playing with fire in different forms, although the specifically oedipal aspects of their difficulties were reserved for discussion in individual treatment.

There is no doubt, on the other hand, that the feminine sex of the therapist introduced a complication in Groups 2 and 3 which contained anxious, defiant, aggressive boys entering or nearing puberty who were

beginning to notice body changes and to cope with the problem of masculine identity and resurgence of the oedipal conflict.

The fact that the therapist was a woman and therefore served as a love object and thus an object of competition rather than of identification for the boys meant that she served as a dividing rather than unifying force for them. It also meant that the boys had no firm, strong masculine example before them, that they could not identify with the therapist as a woman, and that getting close to each other was fraught with homosexual anxiety. Further, such control as the therapist would normally have been able to exercise was rejected as weakening to the masculine vanity and served to increase the need to act out as the strong aggressive male. Thus, her presence was exciting rather than pacifying.

This problem could not be dealt with by ordinary activity group therapy methods which essentially are aimed at problems on an ego level. This was an instinctual oedipal difficulty and had to be dealt with as such.

In the two groups, the difficulty was resolved differently. In one, an appropriate object for masculine identification was temporarily introduced. The boys were able to join together in their identification with the male therapist, to give up to him the mother substitute for whom they had been competing as a love object, and to begin to turn their affections elsewhere, much as in the theoretical resolution of the oedipal conflict.

In the other group, the problem was brought under conscious control through verbalization and discussion of the basic anxiety, which was thus allayed. The need for excessive masculine acting out was consequently reduced; the therapist was relinquished as a love object, and identification with each other was facilitated through a shared meaningful experience.

Thus, with this particular syndrome at the point of puberty, we feel that while it is possible to deal with the situation therapeutically in an activity group led by a female therapist, it does complicate treatment, gives the therapist a difficult time, and changes the nature of the group.

CONCLUSION

Our experience with three groups of boys in latency and prepuberty led by two different female therapists seems to show that with younger children who are not facing the major problem of the establishment of their masculine identity in the resurgence of the oedipal conflict, a therapist of either sex can be used effectively. We have found that a female therapist can work satisfactorily with most of the problems dealt with in activity group therapy, such as those of the passive, dependent boy; the infantile demanding child; the initial phases in the treatment of the hostile with-

drawn boy; the difficulties of the anxious constricted child; and the identification problems of the effeminate child resisting pressure to become more masculine.

However, when boys of eleven and twelve and precocious, aggressive boys who are facing a crisis in their masculine identity are included, this changes the nature of the group because the boys develop an oedipal attachment to a female therapist and the problem can no longer be handled through ordinary activity group therapy methods. With this kind of problem, therefore, we recommend that a male therapist be used or that modifications of technique be planned in advance.

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SEXUAL THEMES IN AN ADOLESCENT GIRLS' GROUP

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When an adolescent comes for therapy, he or she may present varying degrees of pathology. However, all adolescents physically experience sexual maturation and such maturation is accompanied by reactivation of the preoedipal and oedipal conflicts. The struggle to resolve these conflicts therefore dominates the emotions of the adolescent.

Ruth Mack-Brunswick (1940) showed that a girl must replace her intense preoedipal attachment to her mother by turning to her father and accepting him as her new love object. The girl is aided in this complex and difficult step by the accompanying hostility of the preoedipal period which reinforces the new hostility felt toward her mother as a rival. In adolescence, this entire earlier development is recapitulated, but this time there is a new goal: the choice of a nonincestuous love object.

The present paper extracts the sexual theme from an adolescent girls' group in which the discussion over a three-year period clearly reflects this development.

The group, under the aegis of the Girls' Service League, was composed of seven girls who were either American Negro or Puerto Rican. They had been referred for therapy by the New York City Youth Board, the Children's Court, or the Department of Welfare because they exhibited behavior problems such as truancy, hostile and aggressive behavior in school, rebelliousness at home, and shoplifting. An inability to make friends was usually given as a secondary reason for referral. Five of the girls had been diagnosed as behavior disorders; the other two were diagnosed as schizoid characters. They ranged in intelligence from borderline to high average.

All of the girls came from "broken homes." There was no father in five of the households, though two of the mothers had lovers who were in and out of the home. The sixth girl lived with foster parents, and the seventh, a full orphan, lived with a maternal uncle and his wife. All of the girls whose fathers were living (five of the seven) saw their fathers at least once a year.

The group met from October 1956 through June 1959 at a community center in East Harlem. When the group started, the median age of the girls was 13 years and 9 months.

During the first three months of the group, the girls focused on their relationship with their mothers. They complained at first of having to do

¹ Girls' Service League, New York, N. Y.

more household chores than their ten- and eleven-year-old siblings; of being kept out of school to look after younger siblings; of not having food they liked because the mother bought only what she liked. They complained because their mothers "yelled" or "blew their tops" if they neglected chores, came in late, or were seen talking to boys.

From the fourth to the ninth month of the group, the members talked of their mothers very little but complained about teachers picking on them. Teachers were "unfair"; didn't teach them what they needed to know; embarrassed them in front of the class for not having done homework. In May (the eighth month), they complained that both mothers and teachers could accuse and punish and they (the girls) could not hit back. In June the complaint was against women neighbors and relatives who "are always minding my business, checking on me and telling my mother," or "telling my mother what they think I should do."

We hear in this material the anger at the preoedipal mother, who is not all-giving, anger at being expected to perform at home and at school. Accompanying this is the beginning of the complaint that mothers are suspicious and accusing about sexuality.

Fathers and mothers' lovers were discussed until the fourth month of the group. For the rest of the first year their omission from the discussion is notable. Fathers were described, as the mothers had been, as depriving. The group was given to understand that "he's the stingiest man in the world"; "he keeps changing the (TV) channel if he thinks I want to watch something"; or "he told me he didn't have any money but I saw a lot of bills when he gave me the support money." However, the girls thought their fathers easier to get along with than their mothers. Fathers didn't "blow their tops" as quickly; let them talk to boys. In this material the father is characterized, as is the "preoedipal mother," as either giving and feeding or depriving of supplies.

The girls were bitter about their mothers' lovers who were described as "mean," "crazy," or "conceited." They complained that the mother got drunk when her lover was in the home, that the man tried to get the mother to send the girl away, and that "he thinks it's funny if I get a beating." Clearly these men were seen as if they were sibling rivals for the mother's attention and constituted a threat on this level. Complaints that these men were too good-looking and the girls' accompanying expression of distaste for good-looking men suggests that the mothers' lovers were also threatening sexually to them because they were attractive.

The group discussed boys throughout the year. First they discussed them generally. Girls who went to coeducational schools were considered "lucky." Boys who wore sideburns were "cute." The boys at the center

where we met were also "cute." They speculated whether real boys behaved as the characters did in the "True Romance" stories they read.

In the fourth month of the first year they began to talk about dating celebrities, and everyone knew a girl who had done so. About the same time, they brought love poems to the meetings. From speculating about rock-and-roll stars, they moved in the sixth and seventh month to having crushes on boys in the neighborhood and in school. This was accompanied by a preference for songs about unrequited love. It was not until June, the ninth month of the group, that they began to discuss attending boy-girl parties and to talk about their behavior at these parties. They usually went to the parties with other girls, and they were intrigued with the idea that the boys who attended the parties sometimes fought. They complained, self-righteously, that they did not like to dance the "Grind," but it was the only dance the boys knew.

The advance toward boys during this year was slow and steady. First, they speculated and wondered about "boys." Then the girls began to fantasize about them from afar, gradually bringing the fantasy closer to reality. In their earliest attempts at heterosexual socializing, they kept the protection of a group of other girls and they projected their not quite acceptable sexual feelings onto the boys.

At a meeting during the fourth month of the group, they discussed at length an effeminate entertainer they had seen in a stage show. They were fascinated by his mannerisms, make-up, and dress. They recalled other homosexual men they had seen and decided that these men really wanted to be women. They did not like homosexual girls because "they would be interested in the same thing a boy is." They said that they tried to avoid such girls. In the same meeting they then began to discuss people with physical deformities (elephant feet, tremendous weight, and three legs) and came around to their embarrassment at their own moles and birthmarks. Next they associated to various aches and pains they had and to having to be hospitalized for surgery.

As the boys began to become more real to them and as they complained that their teachers picked on them, the girls became concerned about body deformity and mutilation. Here the issue was anatomical: the difference between boys and girls and how they got that way. The "female" was seen as resulting from castration and therefore as being a mutilated being.

In February (the fifth month of the first year) one girl came to a group meeting with menstrual cramps. It developed that all the girls suffered from cramps but none of them had seen a doctor or took any kind of medication. They were convinced that nothing would help.

Two months later one of the girls was asked to take part in a school

fashion show. She refused because she "felt embarrassed by people looking at my knees." The other group members agreed with and supported her feelings. This dread of exhibition typically accompanies the idea of the female role as being one of pain, mutilation, and deformity rather than a state in itself with its own satisfactions. It was about the same time as the fashion show incident that the girls discussed their belief that a woman (married or not) was a prostitute unless she had children. A few weeks later they revealed their idea that a girl is responsible for an out-of-wedlock pregnancy and therefore should not make any demands on the boy. We see here the struggle with sexual feelings. The sexual female is seen as degraded, while mothers clearly do not have sexual feelings. The out-of-wedlock pregnancy implicitly acknowledges the girls' own sexual feelings, which, interestingly, are immediately punished.

It became clear by the end of May (the eighth month) that the girls equated love with abuse and humiliation. They were enraged when beaten or humiliated by parents or teachers but had to believe that these things were done because they were loved. It could be anticipated that their future relations with men would be tinged with masochism.

Since the group meetings followed the schedule of the school year, the girls did not meet from the end of June 1957 until September of that year.

The mother reappeared in the opening sessions of the second year, but in a new role. She was no longer merely the mother who was not all-giving. Now she was seen as forbidding sexual pleasure. This was expressed in displacement onto teachers. The girls were firmly convinced that kissing scenes in school movies were cut out because of the teachers. In the fourth month of the second year they anticipated that their mothers would disapprove of their fantasies about marriage and sex. They spoke of worrying about talking in their sleep because of what it might reveal to their mothers. This came up immediately following a discussion of having dreams about marriage and their attempts to prolong "good" dreams.

By March (the seventh month) of the second year, the girls were in open conflict with their mothers about the way they dressed, the amount of make-up they used, and about smoking privileges. They thought their mothers objected to their behavior because "she grew up in Puerto Rico" and "they did things that way when she was young." Usually their mothers were just considered "mean." Throughout the year there was a contrabass of complaints that they were overworked at home. They had to iron or clean house and their mothers were "too fussy." The girls claimed that they were made to redo chores or that their mothers nagged if things were not done just so—clearly the oedipal mother, forbidding and punishing.

Although the oedipal mother was discussed, the oedipal father was al-

most absent. In fact, any discussion of fathers was rare. When one of the girls was accused by the group of being self-centered, she countered by saying that she put her mother before herself and if her father were living she would put him ahead of herself. Another girl responded to this by saying that she hated her father, but she seemed overwhelmed by what she had said and would not enlarge on it. One girl, whose father was in the household during the second year of the group, complained that her father fussed about how slowly she did the dishes. A few months later, she was quite angry with him because he did not think it necessary for her to remove her curlers and comb her hair before going to the store for him. This complaint is similar to those made against the mothers during this year.

In mid-October of this second year, one of the girls came to a group meeting wearing new earrings, having had her ears pierced. There was some discussion about the procedure and whether or not it hurt. The girls then began to talk about their fear of being molested on the subway when traveling to and from school. One girl told of having carried a hat pin for a year because she had been warned about the boys by her older sister. She said, with considerable disappointment, that no one had ever bothered her. This brought admission from all the others that they had not been bothered either, but they all knew girls who had been. Some of them discovered they were talking about the same girl, and they came to the conclusion that girls could provoke sexual advances by the way they dressed and acted. The discussion then moved to horror movies, how these movies frightened them and how much they enjoyed being frightened. They then observed that the monsters in these films were always chasing or carrying off the heroine, but nothing ever happened to the heroine. The girls seemed disappointed at this. The discussion then turned to the content of horror films that feature as part of the plot the transplanting of brains, eyes, etc. There was some speculation whether these operations were possible and then speculation about various physical deformities the girls had observed.

Here we see the adolescent girl's rape fantasy. The girls made clear that they were pleasurably frightened by the monsters and boys. When they began to sense their wish to participate in sexual activity, their castration fantasies came to the fore and were expressed in their concern about transplantation of organs and physical deformity.

The girls continued to express concern about deformity and body damage through the middle of the second year. However, it was in connection with a new concern about intercourse. When they discussed physical deformity, they usually mentioned or associated their dislike of medical examinations and/or stories of birth mishaps. During the same period they talked of wanting to be blond and to have money, and they finally got around to saying that as girls they felt helpless and blamed.

We can measure their development by comparing their attitude toward the school fashion show during the second year of the group with their attitude of the year before. In April of 1957 they had not wanted to participate because they felt uncomfortable at being looked at. In March of 1958 they were eager to take part.

At the end of the first year of the group, the girls were beginning to go to parties. When the group resumed for the second year, they were discussing the advantages and disadvantages of having a boy friend and the pros and cons of attending coeducational schools. It was generally felt that girls' schools were "jails," but some of the group thought that they would not study if they attended coeducational schools. The girls going to coeducational schools did not think this was so, though they spoke of being embarrassed to recite in front of boys. The question about having a steady boy friend seemed to center around the concern that he might "boss you around."

For the autumn trip the second year of the group, the girls deliberately chose a movie that was a mixture of adventure and romance ("Around the World in 80 Days"). For the Christmas trip, they unanimously chose a love story ("Sayonara"). They also spent considerable time on that trip flirting with the ushers. After January, the second year, when they talked about parties they had attended, it was to tell how popular they had been or to describe the "cute boys" they had met. By spring they were openly flirting with the boys at the center where the group met. Often they were late in coming to group meetings because they "had to talk to a boy." When the group recessed the second June, only one girl was not dating.

During the third year, which was the last for the group, there was something new in the discussion of their mothers. Though they still saw their mothers as sexual rivals, they were beginning to view them as people, not merely projections of their own fears. There were some complaints that their mothers were limiting dating or that "they" did not want the girls to have fun. However, there were also discussions about earning their mothers' trust by coming home when they promised or by keeping their word about where they went. They revealed detailed information about the way their mothers had been brought up and expressed sympathy about some hardships their mothers had endured. For example, they sympathized with the mothers who had not been allowed to date until they were 18, with those who had had to go to work as children, and with those who had been brutally punished as youngsters. One girl complained about being slapped but compared her mother favorably to her grandmother who had punished her mother by making her kneel on rice while holding flatirons on her palms. They talked about their mothers' attitudes toward television programs and dance music. They were not resentful as they had been the year before,

but realized that their mothers liked romantic stories or a dance tune and were either amused or pleased.

There was no mention of fathers the third year, but there was concern about male teachers and tutors. They found it difficult to learn in a class with a man teacher. They accused the men teachers of being seductive. There were many accounts of male teachers who "looked at the girls' legs," who put the pretty girls in the front of the class, and who were stricter with the boys than with the girls. Some of the girls could have had remedial help with a male tutor, but refused it because they felt they could not show a man how little they knew. The girls were again displacing onto teachers the oedipal parent and projecting their sexual feelings onto him.

In the fall of the third year, they were having dates but expressed concern that they lost interest in a boy as soon as he became interested in them. The incest dread was clearly present here also, though their discussion about boys was moving toward a more mature level, that of relationship. They raised such questions as whether they should lie about having a steady boy friend when meeting new boys and how they should treat boys who stood them up. They agreed that boys lied but thought this was necessary if they were going to impress girls. The group members assumed that they would lie to boys in order to "wind them around your finger."

They were interested in, and discussed at length, movies and television programs that dealt with all aspects of the relationship between men and women. They followed a television panel show called "Ask the Girls," the theme of which was the battle of the sexes. They agreed with the female panelists that "women have to lie in order to get along with men." They could not understand one woman who objected to her husband imitating movie lovers; they thought it would be nice to have a husband who acted like a movie star. Another situation reported from the television show was that of a husband who refused to let his wife drive the car. The girls thought the wife should steal the keys or secretly have another set of keys made. Only one girl thought the wife should prove to her husband that she knew how to drive. Here the girls were speculating about adult and marriage relationships with men. It would seem that they envisioned the female role as exploited and therefore characterized by necessary duplicity.

In contrast to the second year of the group when they sought out horror movies, the group members now looked for movies that offered sexual stimulation. They were often disappointed as when they went to a film called "Adam and Eve" and found that it was "only the Bible." "Cat on a Hot Tin Roof" and "The Strange Case of Dr. Laurent" were favorite movies that winter. For their group trips they chose the film "Gigi" and the play "The World of Suzie Wong." They could admit having sexual feelings and their curiosity was now sexual rather than anatomical.

CONCLUSION

In summarizing this discussion, we see that the girls started out talking about their anger at the preoedipal mother who was not the ever-flowing breast and who demanded a standard of performance from the girl in terms of tasks and duty. Later in the first year of the group they began to depict their mothers as sexually suspicious and accusing. Throughout the second year the mothers were pretty consistently characterized as forbidding and punishing toward sexual behavior on the part of the girls—the classic oedipal mother. By the third year, although the forbidding, punishing mother was still present in the discussion, the girls were beginning to see their mothers as people.

There was not as much discussion about their fathers. When the father was discussed in the first year he was pictured as depriving but a little more giving than the mother. There was a hint, only a hint, in the second year that he was seen as sexually forbidding. In the last year fathers as such were not mentioned, but an image of the oedipal father was displaced onto male teachers and the girls' sexual feelings were projected onto these teachers.

The discussion of boys moved from speculation about boys in general to fantasizing about particular boys. These fantasies started with celebrities and gradually moved to boys in their own world. By the end of the first year the girls were going to boy-girl parties, but in the company of other girls. The boys at these parties were pictured as interested in sex and as aggressive. During the second year the girls began to date and were interested in any boy who entered their world. However, in the third year they began to question their quick loss of interest in a boy once he became interested in them. They seemed, in many ways, to be groping toward a more mature level of relationship.

Tracing the group's concept of the female role we see that in the first year the girls were preoccupied with their own anatomy. They saw the female as a mutilated being who was either a Madonna or a Magdalen. Moreover, their own sexual feelings had to be projected or disguised. The second year they revealed their rape fantasies and the fact that they were pleasurably frightened by them. Growing awareness of their own sexual feelings at first aroused castration anxiety and then anxiety about the sexual act and its consequences. By the last year they had moved to the point where they could admit having sexual feelings and their curiosity was no longer anatomical but sexual. At the same time they saw the "female role" as exploited and therefore characterized by a necessary duplicity.

In reviewing this material discussed by an adolescent girls' group, we see that the girls were able to talk about many aspects of female sexuality. The material was conscious or thinly suppressed. Such discussion is im-

portant for adolescents. Could this discussion have occurred, without shame or guilt, in a mixed adolescent group? In a monosexual group girls can discuss heterosexual concerns and specifically female concerns, such as childbirth, without feeling under pressure. Would these things be raised in a mixed group? Or would they be channelized into acting out?

There was surprisingly little discussion of overt homosexuality in this group. The girls certainly discussed their relationship with their mothers and with older women, but there was little apparent conscious concern with homosexuality. Could some of the heterosexual talk have been a defensive maneuver?

It is difficult to evaluate the absence of talk about fathers. Was it due to the specific life situations of these girls? Was it a transference reaction to a female therapist? One wonders if a mixed group would not have been able to discuss both parents more easily?

It has not been the aim of this paper to demonstrate the therapy. However, the girls' identification with and transference to the therapist should be mentioned. Identification with the therapist is important for these youngsters with ego defects. In the transference the therapist is mother or father as the girls need to see her, but, just as important, she is a woman with whom they can identify.

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PARALLEL GROUP PSYCHOTHERAPY WITH THE PARENTS OF EMOTIONALLY DISTURBED CHILDREN

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Reaching the parents of emotionally disturbed children is an important challenge for child psychiatry (Ackerman, 1961; G.A.P., 1957; Langford and Olson, 1951). A variety of methods is available for gaining leverage on pathogenic forces in the family through the treatment of parents (Bell, 1961; Belmont and Jasnow, 1961; Dawley, 1959; Durkin, 1954; Glaser, 1960; Hallowitz and Stephens, 1959; Jackson and Weakland, 1961; Johnson, 1953; Lowry, 1948; Marcus, 1956; Martin and Bird, 1953; Mittelmann, 1948; Ritchie, 1960; Szurek et al., 1942). This paper describes a plan of treatment built around parallel psychotherapy groups for mothers and fathers and specifically designed to meet common problems in clinical work with families. Three of these important difficulties are: (1) parents' lack of motivation for psychotherapy for themselves, (2) faulty communication between family members, and (3) impaired co-ordination of the therapeutic team in the clinic.

Achieving maximum effectiveness in the therapy of a child depends upon attracting both the father and the mother to the treatment process, but motivation problems in parents are often intensified when attempts are made to involve the father actively in treatment. The reluctance of the mother and father to share an interest in therapy frequently reflects pervasive faulty communication patterns within the family (Ackerman, 1958; Beukenkamp, 1959; Eisenstein, 1956; Grotjahn, 1960; Haley, 1959; Pollak, 1960; Ruesch, 1957). As a gross example, one father did not appear at the clinic because his wife had not told him of his scheduled appointments.

If communication patterns are teased out of the complicated matrix of family relationships, one can distinguish conscious and unconscious communication. Both verbal and nonverbal messages are transmitted at each level. In our clinic families, potent unconscious communication occurs between family members, while contradictory, inconsistent, or inadequate messages are transmitted at the conscious level. For example, one set of parents was enmeshed in a "cold war" in which underlying hostilities

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rarely broke through superficial pleasantries. At the other extreme, another family was in continual surface conflict but was held together by strong unconscious bonds. Most often the marriages of our clinic families are quite stable. As an illustration, if a wife projects her hostility on her husband and he characteristically turns his hostility against himself, a mutually satisfying relationship exists. If both parents project their hostility to a child, the marriage is compatible, but the child develops symptoms. In each case the parents have blind spots for their dominant unconscious communications. The projecting wife with a masochistic husband has no opportunity to become aware of her projections since they are readily accepted and unchallenged. Parents dominated by unconscious neurotic bonds cannot rationally deal with each other at a conscious verbal level, and thus they are handicapped in psychotherapy, which depends upon rational analysis and understanding of their behavior in each other's presence.

A third common problem is difficulty in making clinic teamwork a smoothly operating reality (Brody and Hayden, 1957; LaBarre, 1960). Szurek (1952) points out that failures in the treatment of families may result from faulty co-ordination in the clinic. At times a disturbed family induces a similar disturbance in the therapeutic team, staff rivalries and personality differences providing fertile soil for the family's manipulative tendencies. The very contagiousness of family disorder brings into bold relief the necessity of effective co-ordination of the therapeutic team.

In order to meet these problems, our strategy called for a therapeutic design which would capture the interest of both mothers and fathers, stimulate conscious verbal communication between parents as a basis for psychotherapeutic insight, and facilitate co-ordination of the team in the clinic. The ultimate goal was to raise parental communication from a blind, unconscious level to a more rational, conscious plane on which the parents could look at themselves and at each other more objectively.

METHOD

Group psychotherapy was chosen as the core of the program because of its usefulness in rapidly achieving a high degree of motivation in patients. Closed parallel groups of mothers and fathers were formed, tapping the natural curiosity spouses feel when each is in a similar but separate activity (Figure 1). Periodic merging of the groups, it was decided, would stimulate intergroup interest and give the parents an opportunity to see each other in action.

The clinic team consists of a separate therapist for each group, with the same observer in both groups. Weekly stereoscopic meetings of the

The material for this presentation is drawn from five families followed for two years in the parallel group therapy program. The groups met weekly for ninety minutes, with merged joint meetings at three-month intervals. Families with parents between the ages of 25 and 40 and with some college background were selected from the waiting list of the Out-patient Service of Children's Psychiatric Hospital.

At the beginning of therapy the over-all plan illustrated in the diagram was introduced to the parents. The channels of communication in the clinic were described. Appropriate respect for confidentiality outside of the families involved was requested, but confidentiality within the clinic-group-home system was not expected. Although they were not encouraged to discuss the group meetings at home, the parents were told they need not avoid discussions outside of the meetings. We did not directly encourage discussions at home because of the possibility that such a suggestion might cause or prevent outside interaction in an effort to please or frustrate the therapists.

OBSERVATIONS

The observations here are limited to the unique features of this structured treatment plan. We omit reference to the psychoanalytically oriented group therapy process and the treatment of the children for the sake of clarity.

The Hale family was referred because their six-year-old daughter developed the school phobia syndrome after entering the first grade. At the time of initial evaluation, both parents were harmoniously preoccupied with their daughter's unhappiness and somatic symptoms. Because of the severity of her symptoms, Carol was enrolled in the hospital's day school. A part of the pathological interaction between parents and child was their mutual projection of their hostility onto the child. With Carol's improvement in the hospital school, open conflict appeared between the parents as they shifted their projections to each other. At this point, they entered the group therapy program. Carol was discharged from treatment several months later.

As the Hales became involved in their respective groups, "gossip sessions" after the group meetings began to replace their arguments at home. Mr. Hale told his wife of the faults and peculiarities of the other fathers. Mrs. Hale spoke bitterly of the other mothers. They began to displace their projections from each other onto members of the groups, permitting the return of relative harmony at home. In the fathers' group, Mr. Hale's projections were repeatedly interpreted. In the joint meetings the other fathers saw his wife's distortions and later demonstrated them to Mr. Hale.

As he recognized his underlying hostility toward himself, he became clinically depressed. Mrs. Hale, at the same time, intensified her projections onto the other mothers as her husband was less inclined to return her hostility. Her accusations against the other mothers became so irrational that she was forced to face her own infantile conviction that she was unlovable. As Mr. Hale recovered from his depressive symptoms, Mrs. Hale began to show overt depression. She was continued in individual therapy for six months after the couple's two-year course in the parallel groups.

Although there were variations, the outline of the course with the Hales was repeated in other families. With the exception of one case, the children left treatment prior to the parents. All five families terminated with evident clinical improvement in their children and marriages.

The following tentative phases may be distilled from our experience with the five families:

Phase I: The Family Neurosis

On entering therapy each set of parents showed meshing of their neurotic personalities. Both of the Hales were basically infantile, passive-dependent persons who maintained a stable marriage by projecting their hostility onto their children. Their conscious communications centered around worry about their children. At an unconscious level numerous messages revealed their hostility for the children and each other.

Phase II: Displacement to the Group

Projections were readily displaced from family members to the groups, resulting in improved relations at home. "After-group" discussions at home began with gossip about the other families and the transmission of messages between groups. For one couple the discussion of group meetings was the first interaction they had shared without leading to an argument in seven years of married life. The Hales' conscious verbal communication shifted from their children to criticisms of the other parents in the groups.

Phase III: Mirroring in the Groups

Married couples are handicapped in analyzing their relationship because of the blind spots created by the unconscious fit of their defenses. At home their pathological bonds are not recognized because they serve mutual neurotic needs, but in the group these bonds do not fit as well with other members and stand out as inappropriate. With the aid of the therapists and the other group members, the parents begin to see themselves as others see them. Mr. Hale could not continue to remain unaware of his low self-esteem when a mirror was repeatedly held for him at group meetings.

Phase IV: Intrapersonal Change

With parallel groups the separation of spouses permits the gradual working through of insights at a rate consistent with the individual's tolerance of painful affects. The option of temporarily retreating to the old, but partially gratifying, neurotic interaction at home is always available. On the other hand, periodic confrontation with the spouse in the joint meetings keeps the focus on the husband-wife relationship. As the Hales were confronted with their own psychopathology, their conscious communications at home centered on themselves individually.

Phase V: Interpersonal Change

The ultimate goal of this program was to establish a new equilibrium in the family based less on unconscious neurotic bonds and more on mutual conscious tolerance and understanding. In the Hale family the first change was seen in the daughter who quickly improved when she was relieved of the pressure of the parents' projections. Mr. Hale's depression deprived his wife of his hostility which had given a core of reality to her projections onto him. With his later improvement and the appearance of her depression, Mr. Hale was able to partially fill his wife's dependency needs. In this family clinical symptoms shifted from the daughter to the father to the mother, ultimately exposing the mother's chronic depression which was the core of the family neurosis. After this was worked through, the family reached a new equilibrium, with visible evidence of less unconscious mutual hostility.

DISCUSSION

Both mothers and fathers showed a high degree of interest in the therapy groups. The mothers had initially expressed their desire for help through bringing their children to the clinic. The fathers were less involved in the clinic referral and less motivated for treatment for themselves. Meeting in separate groups offered the parents an opportunity to share feelings of guilt and failure with peers. The fathers saw their group as accorded them recognition equal to that given their wives. The parents supported each other in dealing with their spouses during and after the joint meetings. This was particularly true in the case of a passive father who used the other fathers' encouragement to stand up against his wife.

The curiosity stimulated by the separate groups heightened interest and opened channels of communication at home. For example, the mothers used each other as messengers to learn what their husbands were doing in the fathers' group. Husband and wife compared notes about the other families. As they did this, they found themselves talking less about dissatisfaction with their own children. Information transmitted between the

groups underwent distortions that labeled the defenses of the bearer. As an illustration, Mrs. Hale repeatedly complained to her husband about another "rude, inconsiderate" mother. Mr. Hale gradually learned from the other fathers that his wife was in fact the "rude, inconsiderate" member of the mothers' group.

Although they came to the clinic because of their children, the parents rarely mentioned their youngsters as they became involved in the groups. Merging the fathers' and mothers' groups tended to focus the content of the parallel meetings and conversations at home on the marital relationship. The periodic joint meetings followed by separate sessions directly contrasted images developed of opposite partners with first-hand observations. For example, one father portrayed himself as the dominant force in his home. Witnessing his "puppy dog" behavior with his wife in a joint session led the other fathers to challenge his pseudomascularity at the next fathers' group meeting. Several joint exposures and the working through of this confrontation during separate meetings were necessary before he could accept this unconsciously mediated pattern. In his wife's presence, he was unaware of his obvious submissiveness. The parents' unconscious interaction was modified first by conscious attention to the marriages of the other parents, second to themselves individually, and last to their own marriages.

The weekly team meetings in the clinic were leavened by the observer's reactions from her vantage point as a member of both groups. The stereoscopic view of life at home as reported separately by the husbands and wives provided the therapists with useful information for the clarification and interpretation of character operations. How much the open channels of communication in the clinic induced similar channels at home by example can only be inferred. One parent remarked that the presence of the observer in both groups kept her "honest." The clinic team found that this design promoted a harmonious, constructive climate for teamwork.

The usefulness of this program for training group therapists warrants mention. Supervision of two groups can be provided at the stereoscopic conferences. The observer gains experience in group therapy in addition to filling a key position in the design.

SUMMARY

Parallel group psychotherapy is described as a method of inducing change in the families of emotionally disturbed children. The strategy of this program focuses on opening conscious verbal channels of communication between parents as a basis for insight-producing psychotherapy.

The structure of the design with separate mothers' and fathers' groups periodically merged in joint meetings tends to keep the focus of therapy on the marital relationship and sharply outlines the defenses of the members. Phases of the therapeutic course with five families over a two-year period are noted. Evidence of intrapersonal and interpersonal change in one illustrative family is presented.

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PATIENTS' VIEWS OF GROUP PSYCHOTHERAPY: RETROSPECTIONS AND INTERPRETATIONS

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How does the individual patient perceive group psychotherapy? In clinics and other institutional settings referral for group treatment is generally a therapeutic decision based on varying considerations of patient need and treatment resource availability. Group therapists share with individual therapists goals of intrapsychic and behavioral change for their patients. Yet the processes by which change is anticipated are but dimly understood. Outcome studies which evaluate changed performance on psychomotor tasks (Peters and Jones, 1951), altered responses on psychological tests (Ends and Page, 1957) and decreased incontinence (Tucker, 1956) do not help in an understanding of the process by which changes result. Nor are any outcome studies likely to reflect the phenomenal experiences of the patients involved.

This investigation³ was launched with the intention of investigating the phenomenal experiences of patients as primary data. It was hoped that reports of their experiences, whether viewed as successful or unsuccessful, could provide data which could be meaningfully compared with the clinician's observations. In this way a more complete picture of group therapy as a process could lead to a more adequate comprehension of its uniqueness and of its potentials and limitations in application to the individual case.

This study undertook to analyze verbal reports of former group therapy patients. Their characterizations of their experiences in group therapy—its purposes, the manner in which symptoms might be alleviated; views of the therapist, other members' behaviors and themselves—comprised the main focus of the study. A secondary aim was to interrelate characterizations of the experience and to examine relationships between individual characteristics of patients and their particular views of the experience.

THE SETTING

Patients studied had been members of either of two therapy groups which met at the University hospital from one to two and one half years

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TABLE 1

		Population Characteristics					
		Interviewed			Noninterviewed		
	N	Public	Private	Total	Public	Private	Total
		16	12	28	19	6	25
Mean Age ^a		37.25	31.50	34.80	41.74	36.17	40.41
Sex ^b	Male	3	3	6	9	5	14
	Female	13	9	22	10	1	11
Race	White	13	12	25	13	6	19
	Negro	3		3	6		6
Education ^c							
	College graduate	1	4	5		3	3
	High school graduate	8	5	13	4	2	6
	Some high school	1	1	2	3	1	4
	Less than public school diploma	6	2	8	12		12
Diagnosis ^d							
	Psychoneurotic	7	8	15	9	4	13
	Personality disorder	3	2	5	5		5
	Psychosis	5	1	6	3	2	5
	Other	1	1	2	2		2
Mean Number of Sessions Attended		9.25	12.67	10.71	8.89	6.83	8.40
Therapist's Ratings of Improvement							
	Marked to Moderate	3	6	9	3	2	5
	Mild	8	5	13	9	2	11
	Unimproved or Worse	5	1	6	7	2	9
Psychiatrist's Ratings of Improvement at Time of Interview:							
Mean Rank		16.50	11.83				
Mean Weighted Score on WAIS Vocabulary Subscale ^e		9.63	13.50				

a. Interviewed vs. Noninterviewed, $t=1.98$, $p<.10$ (noninterviewed older)

b. Interviewed vs. Noninterviewed, $X^2=11.72$, $p<.001$ (more males in noninterviewed)

c. Interviewed vs. Noninterviewed, high school vs. less than high school $X^2=3.2$, $p<.10$ (Interviewed, more education)

d. Public vs. Private groups, psychoneurotic vs. all other diagnoses; $p=.05$, Fisher's test of exact probability

e. Interviewed, public vs. private, $t=2.19$, $p<.05$

prior to this investigation. One group consisted of individuals referred to the public outpatient clinic; the other consisted of patients referred through the private clinic services at the hospital. The same staff psychiatrist functioned as therapist for both groups. Regulations and procedures were identical. The therapist's practice orientation was to intervene only to facilitate discussion, to manifest interest, understanding and acceptance, and to reflect the affect currently expressed in the groups.

RESPONDENTS

Fifty-three individuals (all patients who had attended at least three sessions) were contacted and 28 agreed to participate in the study. Some came from a considerable distance, though most resided in the local area. Twelve of the 18 members of the private group (67 per cent) and 16 of the 35 members of the public group (48 per cent) were processed. Diagnostic data and history were obtained from clinic files. The therapist had judged the degree of improvement for these individuals as follows: Moderate to marked improvement ($N=9$), Mildly improved ($N=13$) and Unimproved ($N=13$).

Table 1 indicates that the participating sample did not differ from the nonparticipating individuals in the therapist's ratings of improvement, number of sessions attended, diagnosis, or race. The noninterviewed group tended to be older ($p<.10$), less well educated ($p<.10$), and included more men ($p<.001$) than the interviewed sample. Among the private group more individuals were diagnosed as psychoneurotic ($p<.05$), whereas most of the public patients could be described as "somatizers," i.e., many complained of diverse physical disturbance accompanied by low spirits and general ineffectiveness. Private group individuals who were studied had higher weighted scores on the WAIS Vocabulary subscale than did public group subjects ($p<.05$). To sum up, our interviewed sample consisted of former patients in short-term groups; there was considerable heterogeneity with respect to age, sex, education, and diagnosis. Since no significant differences were obtained between representatives of the two groups for most of the above variables, the results were treated together.

PROCEDURES

Participants were interviewed by a psychologist and a psychiatrist. The psychologist employed an interview outline consisting of 16 clusters of questions focused on the following:

1. The personal interpretation of group therapy purposes.
2. The personal interpretation of how individuals benefited from the experience.
3. Personal recollections concerned with preconceptions and anticipations, the experience itself, and postexperience events and attitudes.
4. Personal attitudes toward the therapist and interpretations of his behaviors.
5. Personal attitudes toward other group members.
6. Descriptions of personal behavior and feelings in the group.
7. Suggestions and/or wishes for alteration in therapeutic procedures.
8. Personal interpretations of the nature of psychiatric disturbance.

Responses to the psychologist's interview were recorded, transcribed, and coded. Nineteen categories which appeared to abstract the response themes were defined. Categories were constructed *a priori* and had to be altered in view of additional themes which regularly emerged from the data. Assignment of responses to categories was done by the authors. Seventy-nine per cent of agreement (22 of 28 responses) was accepted as a minimum level of reliability for each category assignment. Average agreement for all categories was 87 per cent. Category assignments about which there was disagreement were discussed and jointly resolved by the raters. Statistical analyses were performed on the basis of expectations of relationships among certain variables. Of the 30 relationships which were anticipated to reach significance, 17 did so at at least the 5 per cent level. The WAIS Vocabulary subscale and a seven-item Value scale were also administered.

RESULTS: DISTRIBUTION OF RESPONDENTS IN THE CATEGORIES

Depending upon judged emphasis in the responses to questions aimed at the individual interpretations of group therapy purposes as experienced, responses were assigned to one of the following categories: *Suppression* (N=8), *Support* (N=16), and *Tools for Action* (N=4). (Definitions and examples for selected categories are given in Table 2.) Thus, more than half of the subjects indicated that the primary mode of help in group therapy is through mutual support. Since there were discrepancies between personal experience and goals which were recognized but not necessarily experienced, responses were also categorized on the basis of respondents' views concerning abstract goals of group therapy. On this basis the distribution was somewhat altered: *Suppression* (N=10), *Support* (N=11), and *Tools for Action* (N=7).

TABLE 2

Category Descriptions and Examples from Interview Protocols

<i>Categories</i>	<i>Definitions for Raters</i>	<i>Examples from Protocols</i>
Therapeutic Modes		
1. Suppression	One forgets worries; gets rid of problems by "talking them off" (with no reference to how this might benefit); recognizes that others are worse off; medication helps.	"I learned that there's always someone in a worse fix than you are." "...to come and talk...to get it off your mind... If you keeps it in your mind it will finally drive you crazy." "What they thought was on their minds was off... It helps to get your mind straightened out." "They would tell us how to cope with problems. If I feel myself getting nervous... I look at the flowers or something." "I guess if you talk you have a feeling of relaxation."
2. Support	Sharing problems with others who understand reduces isolation and brings relief; others have problems too, you're not alone; when someone listens you feel better; one learns to express oneself in a group.	"It lets you know you're not the only person like that... it helps one to learn to express themselves." "When I came I didn't know other people had feelings I had." "It makes you feel good that people get over these things."
3. Tools for Action	Insights gained which can result in behavior changes; one finds solutions to problems and answers about what to do; statements reflecting insight of interpersonal and intrapsychic nature.	"to articulate problems... to understand them better." "... able to see your own feelings in operation in relation to other people's feelings... so that you are able to see things better." "Help each other to understand themselves... suggestions to improve behavior... genuine change."
Locus of Responsibility		
1. Self	The person feels the responsibility to do something; the group is seen as the vehicle and the therapist as the guide for this. Psychic processes involved in the problem and in improvement are owned by the self.	"She managed to do herself a lot of good... was ready to do something, able to use the group to get it done... She... worked harder at it." "The more I talked about it, the more I felt I should do something about it... work it out in my own mind... You get self-confidence and solve problems outside of the group." "If you seek help, you have to try to help yourself... you don't go there for a social meeting." "I don't think it (the group) will cure anybody by itself... up to the individual. If a person goes... with the idea it's going to cure him, it won't. He's got to make up his own mind to help himself."

TABLE 2 (Continued)

<i>Categories</i>	<i>Definitions for Raters</i>	<i>Examples from Protocols</i>
2. Not=Self	The group is a place where you get something. Someone else does or should do something. This can be by suggestion or medicine, or someone permits release of tension. The therapist does or should do this in a special way. The person feels afflicted; psychic processes involved in the problem and in getting better are self-alien.	"It looks like everybody gets help but me . . . I was born to be that way. The Lord made it that way. It (nerve trouble) looks like it will leave them . . . I felt the effect of it all the time. It scares me all the time." "I think it (the group) could (help) a doctor (know) how we feel and how we talk to one another . . . He would get more ideas as to how to help the patients." "I came and just sat and listened . . . I figured they would come up with a problem like yours and someone would tell them what would solve it . . . If you go when you're supposed to when they say you should, and you go until they tell you, you are better."
Felt Social Contact		
1. High Social Contact	Member received something from others in the group; patients helped each other. The relationships were unique in that these people listened to me, understood me, and helped me understand my problem.	"There was something happening. A feeling of affection that I suppose couldn't happen in any other way. . . . it's a bond between other people . . . we understand each other . . . that doesn't happen at home . . . we have something constructive to offer to help themselves . . . and someone else." "You got somebody to listen to you that won't think you're crazy. Maybe understand you." "I felt close to the people I met. I had a feeling of belonging and they were interested in me."
2. Low Social Contact	A social get-together of a group of people who could have been any other with problems. There was nothing unique about them; there was nothing special about the fact that they were there, and they didn't help me in any special way.	"In group therapy . . . I don't like a person that talks too much. A lot of them in there they talk too much. They ask you questions they have no business asking." "A bunch of men and women in there talking about their troubles . . . they seemed to enjoy it . . . I just don't like to sit and tell people my troubles." "I disliked every one of those people . . . turning to me and asking me questions. I felt it was not their business." "I didn't feel as if I had done any more than walk into a department store. They were just as strange to me as anyone outside in a strange place."

Motivation for continuing attendance was classifiable into four categories: *Feelings of Change or Benefit* (N=7), *Expectation of Help from Others*, *Vague* (N=15), *External Pressure* (personal physicians' instructions) (N=3), and *Enjoyment* ("social gathering") (N=3).

Reasons for termination were: *"Inconvenience"* (N=11), *Dissatisfaction* (N=9), *Others Were Responsible* (spouse or therapist's decision) (N=5), *Felt Improved* (N=3). Despite general lack of satisfaction with the results personally experienced, the majority of the respondents (N=17) reported regret and remorse about termination. Four respondents definitely felt improved and satisfied with the results; seven were relieved to be out of the group treatment. Categorization of responses to questions aimed at the rationale for failure in group therapy yielded the following: *Nonparticipation* (a person who does not come sufficiently often or who will not talk) (N=11), *Resistance* (someone who does not want to change) (N=11), and *No Reason* (N=6).

Attitudes toward the therapist were elicited in several of the questionnaire items. The emphasis could be categorized as *Positive*, *Negative*, and *Neutral*. One half of the respondents held essentially neutral attitudes toward the therapist. In addition, in response to items concerned with ways they would like to have had the experience altered, 15 individuals indicated they would have preferred that he take a more directing and supporting role (i.e., answer questions, give directions, give medication, etc.).

In *Characterization* of other group members, one half of the respondents felt that there was some similarity or common concern among the patients in their group; the remainder felt there was nothing in common. Affective reactions to other patients were made *Specific* in 18 instances; 10 made statements about liking all or none of the other members. Perceived affective responses to oneself on the part of other patients were: *Felt Accepted* (N=10), *Not Accepted* (N=5), *Neutral* (N=9), and *"didn't know; didn't care"* (N=4). *High* and *Low Social Contact* was determined for all respondents on the basis of their responses to items concerned with purposes of group therapy, motivation for discontinuing, and perceptions of others.

Perceptions of self-activity level (manner of contributing about the self and to others) were categorized as follows: *Active* (N=7), *Moderate* (N=10), and *Passive* (N=11). In addition, more general assessments of feelings of freedom in communicating about the self and others were distributed as follows: *Relatively Free* (N=8), *Some Inhibition* (N=8), and *Very Inhibited* (N=12).

Group therapy as compared with individual therapy was evaluated as a less personally helpful tool, regardless of whether or not individual therapy had been experienced. Of the 28 respondents, only four expressed a definite preference for group treatment; 19 indicated a preference for

individual psychotherapy; five held no preference. Dissatisfactions ranged from group membership ($N=10$) (types of individuals, turnover in membership) to the previously cited wish for more directive intervention by the therapist ($N=15$). Only three indicated total satisfaction.

Responses to items dealing with therapy goals, treatment preferences, and recalled meetings were used to identify the individual's perception of what may be termed the *Locus of Responsibility* for problem causation and alleviation. Individual responses were categorized as either *Self* for assumption of personal responsibility or *Not-Self*, i.e., disavowal of personal responsibility (see Table 2).

A final item in the interview concerned personal interpretation of the meanings of psychological disturbance phrased as "my nerves are bad." Half the subjects supplied psychological or psychogenic interpretations, such as interpersonal difficulties or feelings of inadequacy in dealing with problems, and half reflected an inability to interpret this beyond the naive somatogenic or somewhat mystical level (e.g., "something that destroys you—kills you gradually—something grabs you").

TABLE 3

Weighted Scores on the WAIS Vocabulary Subscale and Perceived Manner in Which Group Psychotherapy Serves to Alleviate Problems

	<i>N</i>	<i>Therapeutic Mode</i>	<i>Mean^a</i>	<i>SD</i>
1.	7	Tools for Action	16.43	2.44
2.	11	Support	12.18	1.47
3.	10	Suppression	8.20	2.88

^a 1 vs. 2 $t = 4.17, p < .001$

1 vs. 3 $t = 6.33, p < .001$

2 vs. 3 $t = 3.95, p < .001$

RELATIONSHIPS AMONG VARIABLES

Table 3 shows that WAIS Vocabulary scores were related to perceptions of abstract goals of therapy. Individuals who emphasized insight (*Tools for Action*) had higher weighted scores than those who stressed supportive ($p < .001$) or suppressive goals ($p < .001$); those who stressed support in turn exceeded those who emphasized suppression ($p < .001$). Similarly, vocabulary levels for those who offered psychogenic interpretations of psychiatric involvement ($\text{Mean} = 13.79$) exceeded those explanations tending to be somatic or vaguely mystical ($\text{Mean} = 9.86$; $\text{rpb} = .49, p < .01$). Vocabulary levels of individuals who assumed self-responsibility in relation to their problems ($\text{Mean} = 14.70$) exceeded those who attributed cause and hoped-for cure to others ($\text{Mean} = 10.22$; $\text{rpb} = .49, p < .01$). Individuals who

assumed self-responsibility more frequently tended to offer fairly explicit psychogenic explanations of "bad nerves" ($p=.10$).⁴

The value scale, utilized to evaluate the experience from the patient's point of view, had scores ranging from 10 to 40 within a possible range of 6 to 42. High scores indicated low evaluation of the group. Table 4 reflects the unfavorable evaluation by individuals whose responses were rejecting of the group in comparison with other participants ($p<.001$). Those whose

TABLE 4
Point-Biserial Correlations for Value Scores and Categories
Assigned from Interview Protocols

Categories	N ^a	Mean ^b Value Score	rpb	p
Some therapeutic mode experienced by the respondent	16	20.44	.74	<.001
Rejection of the group as not offering any therapeutic mode	11	33.82		
Experienced support as the therapeutic mode	15	17.83	.82	<.001
Did not experience support as the therapeutic mode	12	32.33		
High social contact	11	18.00	.74	<.001
Low social contact	16	31.30		

^a N = 27; these data were not obtained from one S.

^b Low scores indicate greater value.

phenomenal experience was of support evaluated the group more highly than those who experienced other aspects or whose responses were rejecting of the group ($p<.001$). The evaluation of those who experienced higher social contact were more favorable than those who experienced less social contact ($p<.001$). Positive evaluation also tended to be positively related to number of sessions attended ($rs=.33$, $p<.10$).

Rejectors of the group more frequently complained of not having experienced meaningful social contact ($p<.002$). Those who indicated that the therapeutic mode of the group was support were more frequently those who had experienced meaningful social contact with other group patients ($p<.01$). Members who experienced both support as a utility mode and social contact attended more group sessions than did others (N=10,

⁴ Unless otherwise specified, all levels of significance were derived from Fisher's test of exact probability (Seigel, 1956; Federighi).

Mean=15.5 versus $N=18$, Mean=8.06, $p<.05$). Low social contact was associated with little freedom in communication ($p<.05$). As expected, those who appeared to experience more of the latter more frequently described themselves as active in the group treatment ($p<.01$). Also, those who felt accepted by other members more frequently perceived their behavior in the group as active ($p<.02$).

Respondents who expressed either feelings of improvement or regret about leaving the group prematurely more frequently felt accepted by others ($p=.10$); more frequently perceived similarity of some kind among group patients ($p<.05$); and more frequently made specific reference to particular individuals when asked about their feelings about other group members ($p<.01$).

In interviews with the research psychiatrist, current status of the individuals in the following areas of functioning was assessed and rated as to: (1) physical symptoms, (2) work capacity, (3) love capacity, (4) interpersonal relationship capacity, (5) level of social activities and interests, and (6) felt anxiety level. The purpose of this procedure was to assess degree of improvement experienced by the individual and to compare this with therapist's post-therapy ratings. Scores from plus three to minus two (from marked improvement to severe impairment) were assigned for each area. The improvement score was the algebraic sum of scores in each area plus a constant.

Comparison between the therapist's and research psychiatrist's rating yielded positive but low relationships. Markedly improved individuals (therapist's judgment) tended to receive higher ratings by the research psychiatrist than did those of the mild improvement category ($p<.10$) and the unimproved group ($p<.10$). There were no relationships between therapist's categorization of mild and unimproved groups and the later improvement ratings.

DISCUSSION

Although the therapy was variable in length for our subjects, it is representative of many institutional or outpatient treatment groups. Patient interpretations may be viewed as early-stage interpretations if one takes the position that understandings and perceptions of group therapy experience change over time. We present our findings with the expectation that they may be fruitfully compared with those from groups of longer duration or of different composition. The retrospections offered by our respondents have helped us to understand their perceptions of group therapy as distinct from our own.

A striking feature of the patient reports was the heterogeneity of inter-

pretations about what goes on in the groups. The request for retrospections appears in many instances to function as a projective screen and the responses counter any notions that therapy process is viewed in a standard way by patients. We are moved to the inference that patients may use the experience quite differently and see themselves as deriving different kinds of benefit. We found it difficult to contain all of these interpretations within our *a priori* classification system and had to expand it to encompass the diverse views expressed.

Many responses are puzzling, and individual patients seem to be inconsistent in their recollections. However, if "anticipations" are compared with "experiences" the results seem to form a more logical pattern. Few members emphasized feelings of improvement after they left the group and yet the majority seemed to have carried away positive feelings toward their experiences, indicating regret for having terminated. The findings suggest certain disappointments, as well as certain values. The disappointments may be understood in terms of expectations which were not met. If, for many patients, the cause and cure of their difficulties are perceived as external to the self, then it might follow that these individuals feel helpless before their difficulties and that only a powerful external force, in the form of a doctor, is seen as able to effect a cure (Frank, 1961). Other patients apparently anticipated an intensive, insight-oriented therapy group and expected that the therapist would actively direct the group in this way. These individuals apparently did not find that their therapist responded as anticipated. There is evidence that although patients did expect certain actions on the part of the therapist, since many wished that he had played a more active role in the group, he was in fact perceived as being "neutral." These findings support Spotnitz' observation that the patient's initial approach in group therapy is to "look to the therapist to do the whole job" (1960). That expectations and hopes regarding therapist activity were not changed is inferred from the patients' overwhelming preferences for individual psychotherapy in the event of having to return to the clinic.

Although direct help from the therapist was an unfulfilled expectation, patients' responses implied that something of value was derived from their experiences. The obtained interrelationships among value scores, the feeling of having experienced meaningful social contact with group members, and the experience of social support as the chief therapeutic mode of group therapy suggest that participants derived value (perhaps unexpectedly) from being able to belong to a group, to share problems, and to commiserate with and comfort each other. The relationships between feelings of attachment to the group (remorse, regret, etc., after termination) and feeling accepted by group members, perceiving similarities among members, and differentiating members on an affective basis also

USE OF GROUP DYNAMICS IN THE TRAINING AND SUPERVISION OF GROUP THERAPISTS IN A SOCIAL AGENCY

ELSA LEICHTER¹

In my experience with the training and supervision of group therapists, I have become increasingly convinced that the traditional ways and methods of training do not fully capture those aspects of the therapist's functioning which are characteristic of him and which come into bold relief when he finds himself confronted with and exposed to a therapy group. The anxiety-provoking impact and the stress of the group therapy situation tend to intensify the therapist's existing ego defense patterns; transferential and countertransferential reactions on the part of the group therapist are more readily elicited; his narcissistic and omnipotent strivings become more blatantly apparent.

Neither the seminar method nor individual supervision seem able to convey to the therapist more than an intellectual awareness of his patterns of operation in the group, especially since these patterns often are ego-syntonic in nature and, therefore, most difficult for the therapist to grasp fully. Thus, it appeared desirable to create a group training situation in which group therapists would be directly confronted with and hopefully gain insight into those patterns of their functioning which were seriously impairing their efforts. Similarly, the dynamics of group therapy in general could be more easily understood if group phenomena occurring within the training situation could be brought to light and handled. In planning this training program, it was clarified that it should not be converted into a group therapy situation in which the aim would be total personality change of the participating therapists. The training and educational objectives would need to be preserved. Also, while conceptualization would remain a part of the training process, it would, to a considerable extent, emerge out of what was actually experienced in the group training situation rather than take place in the realm of purely intellectual discussion.

A training program for group therapists has been functioning at the Jewish Family Service in New York City for nine years. The philosophy of training shifted only gradually from a didactic, largely intellectual approach to an ever-increasing appreciation of subjective, interpersonal phenomena within the training situation itself. This paper will describe some experiences with group training workshops conducted by the author.

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Each workshop consisted of eight to ten therapists, most of whom had either completed their personal analyses or were in analysis concurrently with the training program. The workshops usually met once a week for one and one half hours. The accepted frame of reference for a session was a specific therapy group, presented by that group's therapist. Attention was paid not only to what the therapist presented but also to the manner in which he made his presentation: how did the group and the leader respond to him? Similarly, transferential or countertransferential elements in the behavior or reactions of the individual therapist, the group, and the leader were identified and discussed.²

THE GROUP AS A "WHOLE"

There are certain points in the group therapy process when "the group associates, responds and reacts as a whole" (Foulkes and Anthony, 1957). This phenomenon also prevails in workshop training groups. For example, a workshop composed of new group therapists was helped to express the members' fear of getting started with therapy groups when the leader pointed out as resistance attempts to involve her in discussions of theoretical questions which were far afield and had nothing to do with the question of screening, the topic which had been planned for that particular meeting.

When another workshop developed a tendency toward lateness and absence, the leader raised this as a resistance phenomenon. The participants were then able to express the anxiety which had been aroused by the intensity of previous workshop sessions.

There was quite a bit of reluctance on the part of a new training workshop to react openly to the minutes of previous sessions, leaving the burden of this on the workshop leader. When this was pointed out as a form of resistance, the workshop acknowledged its difficulty with "putting one of their peers on the spot." Following this expression of a group feeling, individual participants verbalized their own specific fears and anxieties in different ways. One talked of fear of retaliation; another talked of his fear that his minutes would show up his difficulty with integrating other peoples' thoughts and feelings, a fear that later made its reappearance in this therapist's work with his therapy groups.

In all these situations a conceptual discussion of various forms of group resistance emerged out of the joint experience and, therefore, was more meaningful than a purely theoretical discussion of this phenomenon could possibly have been.

² I am very grateful to the participants in the workshops and especially to the individuals particularly mentioned in this presentation for permitting me to disclose experiences which were intensely personal in nature.

INTERACTIONAL PHENOMENA WITHIN THE GROUP AND WITH THE LEADER
OCCASIONED BY PRESENTATION OF MATERIAL

The presentation of material by the individual therapist, a process in which supposedly the help of the workshop is sought and given, can be and almost always is anxiety-provoking. Transferential and countertransferential reactions on the part of the group toward the individual presenting therapist and/or the leader and on the part of the therapist toward the group usually come into play. It is only natural that the leader's responses toward the individual therapist and/or the group also may carry a transference or countertransference flavor.

In a workshop session in which a participant's material was being discussed, the leader gradually became aware that, contrary to their usual way of working, the workshop participants were anxiously feeding answers to the person whose material was under discussion, while he remained relatively passive. There was a decided lack of vitality in this interchange. As the leader questioned what was going on and how the workshop was experiencing the therapist, much feeling was aired and the lethargy lifted. The workshop felt it had somewhat guiltily yielded to a demand for specific answers, that the therapist was sitting back and was permitting himself the luxury of accepting or rejecting the contributions of his peers. They began to realize that the therapist had not really taken responsibility for letting the workshop know what troubled him or what he wanted of them and that they had been busily filling in a vacuum he had created. As soon as the discussion took this turn, the therapist revealed his anxiety by calling the discussion "chaotic" and asked that the workshop return to some specific question. However, the workshop continued to focus on the process rather than on content. Through their own countertransference response to this therapist, the workshop participants had been helped to obtain a deeper understanding of how this therapist operated in his therapy group which related largely on the level of angry demand.

Some therapists whose groups are, as a rule, strongly leader-centered, act out in the training workshop their pattern of mistrust and fear of their peers by using the workshop leader as a buffer between them and their colleagues. One therapist called the leader before the workshop session in which he was due to present his material to tell the leader how he wanted the session conducted. In the subsequent workshop session the participants, sensing this therapist's false use of them, expressed their feeling that the therapist did not really seem to want anything from them. The leader then shared with the workshop the therapist's call to her prior to the session. This brought into sharp focus a long-existing feeling on the part of the training group participants toward the particular therapist: that he kept his

peers away from him and was concerned only with approval from the leader. Seating arrangements, his always looking at the leader when he spoke, etc., were brought up, and previously unexpressed annoyances toward this therapist were now verbalized. The therapist asked the workshop why they had withheld their feelings from him for so long, was he so fragile? One person responded that it was her own fragility that had kept her from being honest with the therapist, but then added that the leader had been favorably disposed toward the therapist (as exemplified by a certain degree of protectiveness) and that this had made it even harder to be honest.

The last remark startled the workshop leader, but through it she realized that actually she had been annoyed with the therapist, as had the workshop, but had not been fully aware of her feeling. Her protectiveness had been a reaction formation against her hostile feelings toward the therapist, and the leader shared this with the training workshop.

In the following session there was considerable confusion about the minutes of the above-mentioned session; the workshop leader and several workshop participants had not read the minutes or had "forgotten" to bring them, etc. As the workshop took another look at what had occurred, it quickly became apparent that the leader's self-posture had been anxiety-provoking, not only to herself but to the training workshop as a whole. One workshop participant revealed her transference need for the authority figure to be perfect, to make no mistakes. While there was awareness of the irrational quality of this expectation, the training group and the leader recognized that some of the latter's own unresolved perfectionistic strivings had merged with the workshop's infantile image of her, and these had served to feed each other. Following this mutual experience, much greater freedom on the part of the workshop participants with each other and the leader became possible.

Another therapist presented to the workshop the problem of considerable acting out on the part of her therapy group. The response of the workshop to the presenting therapist was somewhat cautious, cagey, and protective; they "explained away" the reasons for the problem in terms of the composition of the therapy group, which, while it had some basis in fact, was an evasion of the real issue. The therapist expressed puzzlement over her colleagues' cautiousness and wondered why they were withholding their reactions to her role as therapist. Gradually, several participants brought out their anxiety about criticizing this particular therapist, who was a rather highly esteemed person commanding a good deal of respect and admiration for her contributions in the workshop and her qualities of gentleness and kindness. The training workshop was obviously fearful of frankly questioning and examining why this particular therapist elicited so much aggression in the therapy group which she conducted. One of the

workshop participants likened his reaction to the therapist to the guilt a child might have in attacking an obviously hard-working, well-meaning mother. This particular statement crystallized for the workshop its own countertransference reaction which had led it to be overly protective of the therapist, thereby avoiding the issue of the therapist's unresolved problem with hostility. The reticence of her peers to respond to her directly had shocked the therapist; she verbalized this in the question: "Am I killing by kindness?"

In the course of this discussion (which spanned several weeks) the workshop leader became conscious of a vague sense of uneasiness which she gradually recognized as anxiety. In the leader's re-examination of her own relationship to the therapist, she felt that, to some extent at least, it had also been countertransferentially determined. In these terms, the therapist represented to the leader her younger, admiring sister. The leader had always responded very positively to the therapist's gentleness, kindness, and quality of giving, but she had subtly blocked and discouraged the aggressive aspects of the therapist's functioning, thus helping to perpetuate a pattern which interfered with the therapist's good therapeutic ability. Although this was not an easy thing to do, the leader shared some of her insight with the workshop.

Following this, the therapist brought to the workshop a case which was being co-operatively carried by her and the leader. She criticized what she felt to be the latter's harsh way of handling herself in a jointly carried family interview. This was perhaps the first time in their association that the therapist permitted herself to show some open criticism toward the leader. Subsequently, this therapist's work in her therapy group showed a decided change toward firmer direction and decreased fear of hostility, and her therapy group responded with a sharp decrease in its acting-out behavior.

CONCLUSION

While the focus in this presentation has been on the phenomena occurring in the here and now of the training situation, I should like to stress once more that objective discussion of therapy groups and of individuals in the therapy groups was always an important part of the total training process.

The utilization of the dynamics resulting from the training situation enabled the majority of the workshop participants and the leader to obtain a deeper understanding of group therapy processes in general, as well as of their own and each other's functioning and patterns of relating in their respective therapy groups.

In this process it was necessary for the workshop leader to bring her-

self and her own reactions into the training situation, and this added another dimension to the subject under discussion. The leader and almost all of the participants experienced a sense of personal growth as they were increasingly able to take risks with each other and to respond to each other more openly and more honestly. More importantly, however, this process generally had the effect of breaking into the workshop's infantile image of an omnipotent and omniscient authority figure. To the extent to which this occurred, it helped reduce the therapists' own omnipotent strivings. This, in turn, freed their group therapy clients to use their own inner resources in the therapeutic process more creatively.

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CRITERIA USED BY GROUP PSYCHOTHERAPISTS FOR JUDGING IMPROVEMENT IN PATIENTS

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At each annual training Institute of the American Group Psychotherapy Association since 1960, questionnaires have been distributed to assist with the evaluation of the Institutes and to provide bases for planning in future years. The present writers, serving as research co-ordinators for the Institutes since 1960, have attempted to contribute to the educational process of the Institutes by adding to the regular evaluation forms questionnaires that might be provocative of new directions in thinking for the respondents. Early efforts were addressed to problems associated with the composition of groups and the admission of new members (Rosenbaum and Hartley, 1962). More recently, the questions have been designed to stimulate consideration of criteria used for judging progress in a group and a confrontation of the role of the values of the therapist in his practice. The present summary is designed to provide feedback on the material contributed by the participants in the 1960 and the 1961 Institutes on the subject of the criteria used in judging improvement in patients.

Although descriptive data on the registrants at the Institutes of the AGPA are available, there is no basis for assessing the selective features that determine registration and compliance with the request for the completion of the questionnaire forms. We therefore have no estimate of the population represented by the sample here being reported on. The population surveyed may or may not be representative of all group psychotherapists. Registrants may be attempting to find additional training because they are rather limited in training, or they may be more highly skilled psychotherapists who are attending an institute in order to enhance their skills. Informal surveys have indicated that the majority of practicing group psychotherapists have not had specific training in group psychotherapy but are largely self-taught. The report, in consequence, is not descriptive of an identified population; nor is it hypothesis-testing in any sense. It is the hope of the writers that this communication may contribute to increased recognition of some of the problems involved, improved communication about the problems, and perhaps the development of significant and researchable hypotheses which may be adequately tested in the future.

At the 1960 Institute of the AGPA, the registrants were asked to describe as concretely as they could the criteria they used for judging the im-

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provement or progress of their patients. The question was presented in an "open-ended" form and the respondents used whatever vocabulary and terminology seemed to them most appropriate. Responses were subjected to a content analysis which yielded the classification employed with the 1961 Institute and which was as follows:

Below are listed criteria which group psychotherapists have used to judge the progress (improvement) of their patients. Read through the list and add to it any additional criteria *that you use*. Next, please select the three criteria you consider most important. Place a "1" before the criterion you think most important, a "2" before the second most important, and "3" in like manner:

- _____ symptom-reduction
- _____ improved interpersonal functioning in and out of the therapy group
- _____ self-acceptance; self-confidence; self-reliance
- _____ insight; self-awareness
- _____ expression of feelings, both hostile and loving
- _____ working through of transference
- _____ flexibility, the ability to cope with and adapt to a variety of experiences
- _____ other (please describe)
- _____ other (please describe)
- _____ other (please describe)

Only a small number of respondents found the prepared listing of criteria sufficiently unsatisfactory to warrant writing in "other" categories; two respondents felt that the list represented so many interrelated functions that a ranking could not be made. Several respondents checked off several of the criteria listed rather than ranking them. A few others classified several of the items as "1" and several others as "2." Some respondents returned the questionnaire with this item unanswered and many more failed to return the questionnaire. In all, 81 questionnaires were received with ranking sufficiently clearly indicated to permit tabulation in simple form. The professional affiliations of these respondents were:

Medical: 43

Psychological: 23

Social Work: 15

In Table 1 is reported the total number of inclusions for each criterion among the top three for each respondent, without differential weighting for whether the ranking was 1, 2, or 3. This is tabulated for those with different professional affiliations separately, as well as for the group as a whole. In Table 2, the summaries are restricted to the criteria ranked first (rather than all of the top three).

TABLE 1

Frequency of Inclusion of Each of the Criteria among the First Three Ranks of Importance to Group Psychotherapists of Different Major Professional Affiliations

	<i>Medical</i>	<i>Psychol.</i>	<i>Soc. Work</i>	<i>Total</i>
symptom-reduction	14	4	4	22
improved interpersonal functioning in and out of the therapy group	41	17	12	70
self-acceptance, self-confidence, self-reliance	23	14	12	49
insight, self-awareness	11	6	5	22
expression of feelings, both hostile and loving	7	3	1	11
working through of transference	5	4	2	11
flexibility, the ability to cope with and adapt to a variety of experiences	26	18	9	53
other	2	3	0	5

TABLE 2

Frequency of Inclusion of Each of the Criteria as Most Important (First Rank Only) in Judging Improvement by Group Psychotherapists of Different Major Professional Affiliations

	<i>Medical</i>	<i>Psychol.</i>	<i>Soc. Work</i>	<i>Total</i>
symptom-reduction	4	0	1	5
improved interpersonal functioning in and out of the therapy group	18	9	6	33
self-acceptance, self-confidence, self-reliance	7	6	4	17
insight, self-awareness	4	0	1	5
expression of feelings, both hostile and loving	1	0	0	1
working through of transference	0	2	2	4
flexibility, the ability to cope with and adapt to a variety of experiences	9	5	1	15
other	0	1	0	1

It is interesting to note that there is relatively little difference in ranking of the importance of the criteria by those of different professional affiliations. The same three criteria are at the top of the list for each of the three affiliations when the combined top ranks are used as in Table 1, and only one slight inversion appears when the top rank alone is used in Table 2. In Table 2, the ranking of "working through of transference" as third in importance by those with social work background is based on only *two* selections as compared with the total of but *one* for the "flexibility" criterion which rated more highly among the other professional groups. Clearly, we are dealing with a very minor difference that may be a function of the small number of respondents with a social work affiliation.

For the group as a whole, the top three criteria for judging improvement in patients are improved interpersonal functioning in and out of the therapy group; self-acceptance, self-confidence, self-reliance; and flexibility, the ability to cope with and adapt to a variety of experiences. The gap between the frequencies with which these criteria are selected in comparison to those that come lower in the order: symptom-reduction, insight and self-awareness, expression of feelings, and working through of transference, is quite marked and may represent a truly significant difference among therapists.

In his survey of the variety of stated aims of therapists, Corsini (1957) noted that it was appropriate to classify objectives as being primarily intellectual, emotional, or behavioral. The respondents in the present survey seem to place major emphasis on behavioral criteria, particularly in the social realm, rather than on the emotional or intellectual functions. It would be interesting to speculate at length on whether the present data are truly representative of group therapists, how institutional practitioners compare with those in private practice, how group therapists compare with individual therapists, how the rubrics used in the questionnaire are concretized in the actual observations of the therapists, etc. These questions, however, must be deferred in the light of the very limited objectives of this report.

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AN EXPERIMENTAL GROUP OF MARRIED COUPLES WITH SEVERE PROBLEMS

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A psychotherapy group, formed at the Black Hawk County Mental Health Center clinic and consisting of four couples with severe marital problems, has been meeting for one and a half hours weekly since August, 1959. Initially, all group members demonstrated severe neurotic character disorders, and there had been multiple separations and episodes of sexual infidelity in three of the marriages. Forming such a group was frankly experimental since, at that time, we had no knowledge of a similar previous approach. We felt that the group might be particularly useful in dealing with problems of intramarital communication and of acting out in the marital relationship. Some of the group members had been in individual psychotherapy for a short time before the group was formed, and as the group progressed it seemed necessary to involve all members in concurrent weekly individual therapy. The psychiatrist-author is group therapist and the psychiatric social worker-author is group observer. The individual therapy has been handled by both authors and by two other staff members. The methods and goals for this group have been those of psychoanalytically oriented group psychotherapy, the goals including eventual development of insight into unconscious emotional conflicts and modification of personality defensive systems. At the time this article is being written, it is felt the group has passed through the initial phase of therapy and is well into the middle phase (in terms of three phases of group therapy).

THE COUPLES

Couple A came to the clinic through the wife, who had been advised by another agency to divorce her husband. Alice and Art were high school graduates in their late twenties who had been married for eleven years. The marriage had been characterized by repeated sexual acting out by both, problem drinking by Art, and occasional physical violence. There were three children and the eldest son had shown serious behavior problems. At the time of group formation, this couple had been separated for three months and was seriously considering divorce.

Couple B was referred for follow-up treatment of the wife by a state psychiatric hospital. Beth and Ben were in their middle twenties, had been

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married for five years, and had three children. There had been frequent violence in the marriage, repeated separations, and sexual acting out by both partners. Beth, a high school graduate who had been married once before, had been hospitalized because she feared losing control of herself after an affair. She had not become overtly psychotic, but psychological testing indicated a weak ego and tenuous reality contact. Ben was a senior college student with a pervasive interest in body contact sports who was quiet and taciturn when sober but who would often go out with "the boys" on week ends and get into drunken brawls.

Couple C was referred because of the serious behavior problems of their middle child. Cora and Carl, high school graduates in their early thirties, had been married thirteen years and had three children. Eight years earlier their marriage had deteriorated into a hostile, withholding relationship. Cora often had temper tantrums during which she beat her young sons or drove them from the house. The couple's sexual adjustment was extremely poor and Carl was impotent from time to time.

Couple D was referred by a private psychiatrist, to whom Dave had gone for evaluation of his wife. Doris was shy and unsure of herself and had obsessive suspicions of infidelity on the part of her husband. Dave, a college graduate in his middle twenties, had left his field of training because of personality difficulties and was employed by his father as a salesman. Couple D had been married one and a half years, had not been separated nor sexually unfaithful, and Doris was currently eight months pregnant with their first child.

Couple E, one of the original couples in the group, was dropped after five meetings because it appeared that Mrs. E was too sick for the group. She had been in psychiatric treatment intermittently for the previous ten years and had been hospitalized for an acute schizophrenic episode shortly before the group was formed. The marriage had been characterized by repeated separations and both partners were infantile and demanding.

INITIAL PHASE OF THE GROUP

The group started with couples A, B, and E. Alice and Beth put great pressure on Art and Ben to talk in the group by assaulting them with a barrage of accusations but blocked their responses by interrupting and disparaging them. Couple D was added to the group at the fourth meeting to give balance by providing an aggressive male and a passive female, as well as a couple with better control over acting out. Doris was quiet and constricted in her expression of feeling during the early part of the group. Dave was quite verbal and defended himself through intellectualization and denial. His defensive maneuvers evoked considerable hostility from

the other members who put pressure on Dave to say what he meant. During the first four meetings, couple E tended to sit holding hands and to deny that they had any problems. Their behavior provoked hostility from the other members and had a dampening effect on interaction. Both Mr. and Mrs. E wanted to leave the group and were allowed to do so after the fourth meeting. Couple C was then added in the fifth meeting to fill the group out to a total of four couples. The behavior of couple C paralleled that of couples A and B. The passive, withholding behavior of husbands A, B, and C was intensely stimulating to their wives but became obvious as a defensive maneuver in its own right only later, when the verbal attacks of the wives had been brought under some control. In the sixth meeting, with the restraining influence of couple E removed, Ben finally said that he felt he no longer loved his wife. Beth erupted with intense feeling, smashed an ash tray on the floor, and fled from the room, returning only toward the end of the meeting. As the initial phase progressed, the patients followed the lead of the therapist in helping Alice, Beth, and Cora to limit their verbal assaults and in helping Art, Ben, and Carl put their feelings and thoughts into words. By the sixteenth meeting the group had begun to be aware of the operation of their marital neuroses within the group as resistance and were then able to formulate an immediate group goal of controlling their defensive behavior enough so that free communication could take place.

MIDDLE PHASE OF THE GROUP

Beth's awareness of the group goal seemed to help her become able to apply it to herself. As she became exposed to more of Ben's feelings and doubts about her and about the continuation of their marriage, she became desensitized and was able to listen without the loss of control she had previously experienced. Ben was able to express his feelings of loneliness and isolation and his desire for a companionship within the marriage which he had not found. Alice and Art had to struggle for many weeks before they could translate acceptance of the group goal into application to themselves. Their increasing ability to control their defensive behavior and to improve communication was recognized and approved by the other members. The group helped them see that Alice treated Art like a little boy but that Art actually acted like one. After six months in the group, Art was started in individual therapy at his request. With considerable support from their individual therapists, both partners were finally able to reveal their extramarital sexual acting out to the group and to each other in a climactic meeting. Although both had been fearful that such a revelation

would be extremely destructive, they discovered that they felt relieved and had a better understanding of each other's needs for affection and dependency.

Cora and Carl showed the greatest resistance to therapy and lagged somewhat behind the other group members in acknowledging personal problems. Around the fourth month of the group meetings, their resistance appeared as nonpayment of clinic fees; they were seen in three supplemental joint interviews with their two therapists and firm limits were set on what would be expected of them if they were to continue in treatment. They began payment and a decrease in the manifestation of their marriage neurosis in the group was seen. A few weeks later they underwent a crisis when two of their boys were expelled from school for conduct disturbance and a court hearing was scheduled to consider removing one of the boys from the home. Just prior to the hearing, Carl disappeared with the two boys, and Cora threatened suicide and was hospitalized for a few days under the care of the group therapist. With support from both therapists the couple was able to effect a reconciliation and began living together again, although Carl remained out of therapy for two months. Cora received support from the group for continuing the marriage and remaining in treatment, and when Carl eventually returned to the group, he also received support, rather than the expected attack. After the court sent one of the boys to a psychiatric hospital for residential treatment the C's progress in therapy became more marked. Carl became able to accept individual therapy and to begin working on some of his own problems.

After several months in the group, Doris began to lose some of her fear of the other women, seemed able to identify more with them, responded to their support, and was able to speak up against her husband. Dave was resistive to recognizing his own involvement in the marriage problem and for many months asserted that the only reason he came was to help change his wife. As a result of the group repeatedly pointing out his intellectualization and denial, he gradually developed anxiety and began experiencing outbursts of angry feeling in the group. He was eventually able to acknowledge that he had never wanted to take a stand on anything for fear he might be hurt. After ten months in the group he accepted individual therapy to help him work on his own problems. Doris and Dave were finally able to reveal to each other that each had not wanted their first child, and this led to the further discovery that each had the feeling they had come between their own parents as children. In Doris' case, this led to the abreaction of repressed feelings of rejection by her father. The group has lately become increasingly active in bringing out childhood material and in relating hostile and distrustful feelings toward

members of the opposite sex to experiences with parents and siblings. In some cases the traumatic childhood memories appeared first in individual therapy and were later brought to the group, and in other cases the early experiences came out as a result of associations between members in the group.

At present, couples A, C, and D remain in the group and are undergoing concurrent weekly individual therapy. All members feel that they have derived some benefit from therapy thus far and have noted improvement in their marital relationships but are anticipating being in therapy for perhaps another two years before deriving maximum benefit. Couple B left therapy in June, 1960, when Ben graduated from college and had to move to another city to obtain a position. Although both had shown marked changes in behavior, both in the group and at home, they were still actively engaged in working through transference material in therapy and accepted referral to a clinic in the new community to continue their psychiatric treatment.

OBSERVATIONS AND REMARKS ON THE GROUP AS A WHOLE

Grouping

The patients in this group had not made a final decision to dissolve their marriages. Perhaps underlying fears of rejection led them to cling to the partner. Their motivation in beginning therapy was not primarily that of recognition of and desire to overcome individual problems but of changing the spouse. After the marriage neurosis had been recognized as resistance in the group and brought under partial control, motivation broadened to include a desire for personal change. It was felt desirable to have some heterogeneity of marital interaction patterns in the group and to have at least one couple which did not act out sexually. The one couple which was dropped from the group was seen to have been a poor choice because of the severe psychopathology of the wife.

Patterns of Communication

Early in the group's existence, communication between partners occurred almost exclusively as the expression of hostile feelings from the active to the passive partner. There was practically no feedback, since the counter expression of anger was suppressed by the more passive spouse. As the group progressed, an indirect communication pattern developed in which one partner would express feelings or thoughts to someone other than his spouse, or an unrelated group member would interpret the partner's feelings to his spouse. Communication then progressed to the point

at which there was relatively free interchange of feelings and thoughts back and forth between spouses, even to the point of communicating inner needs.

The Marriage Neurosis as Resistance

The initial phase of this group was characterized by a particular type of resistance, that of re-enactment of the marriage neurosis (primary pathological interaction pattern of the couple) within the group. Movement into the middle phase occurred when the group was able to recognize and deal with this resistance to the extent that an individual group member could talk freely without being suppressed by the marital partner. They were then able to express and examine their own feelings, needs, and inner conflicts. However, something more than the working through of resistance occurred. Controlling the marriage neurosis within the group had an experiential impact upon the couple which brought increased control over the marriage neurosis outside the group, with improved functioning of the marriage. This improvement has not deterred the patients from further therapy but, rather, has helped change the goal from that of modifying the partner to that of understanding and changing themselves. A manifestation of decreasing resistance in the middle phase as compared to the initial phase has been group attendance. In the first twelve months there were only 15 sessions with no absences, while in the last three months there have been 12 sessions with no absences.

Factors Favoring Ego Development

An early supportive element was the relief experienced by all members on discovering that they were not the only ones with severe marital problems and impulses for dissolution of their marriages. This was repeated as it was discovered that most members shared such guilt-inducing problems as sexual inadequacy or deviation, hostile feelings toward children, and wishes to be given to and to be taken care of. Reality testing was enhanced by repeated confrontation of individual members by other members regarding distortions in attitude and thinking, and this had a particular impact on the irrational projections of marital partners upon each other. Considerable strengthening of identification between members of the same sex has occurred. This was most notable in the case of Doris, who early in the group appeared fearful and suspicious of the other women and on one occasion described herself as being more like the passive males in the group than the aggressive females. By now, Doris has become more active verbally and is identifying strongly with the other

women, and they have been able to become more passive. This change has been largely experiential, since unconscious sexual identifications have not yet been worked out to any extent.

Acting Out

Considerable acting out took place in the initial phase, evidenced as absence from meetings, running out of a meeting, excessive drinking on week ends, temporary separations, extramarital affairs by both members of couple A, and beatings by husbands. This was a continuation of pre-group behavior (except for the first two), although temporary intensifications could be considered related to therapy. The acting out diminished as the group entered the middle phase. Acting out in this particular group was controlled to some extent by the fact that it was difficult for a single member to do something without at least one other member, the spouse, being aware of it and bringing it up in the group for consideration. No extramarital sexual acting out occurred between group members. One interesting phenomenon was the occasional planned absence of one partner for the expressed purpose of making it easier for the spouse to talk in the group. Invariably the related material was later given the absent partner by the group. Another phenomenon was the tendency of some couples to get into a fight just before coming to the group session so that the marriage neurosis was brought to the group in full flower.

Transference Manifestations

Early in the group there was considerable direct expression of angry feelings from spouses to group members of the opposite sex. This served the useful purpose of partially diluting hostility toward the marital partner. At first, most members tended to have negative feelings toward the therapist and perceived him as ungiving as he did not take sides and did not offer advice and direction. Members took it as criticism and attack when he pointed out what he observed to be going on in the group. Feelings of the women toward the silent group observer, who is also their individual therapist, tended to be positive and he was seen as someone who listened to and gave to them. Positive feelings toward the therapist appeared later, most dramatically in the case of Alice. She sat beside him and expressed warm feelings toward him for several meetings until she suddenly realized that he was a young, rather than an old, man and moved to a seat on the far side of the room. She then became aware of seductive fantasies toward him which she discussed with her individual therapist but has not yet brought into the group.

ACTIVITIES OF THE THERAPIST

As indicated, the therapist was relatively inactive at first, his activity increasing as the group entered the middle phase of therapy and became more able to utilize the pointing out of emotional responses and meaningful behavior, requests for associations and dreams, and interpretations. In the initial phase the therapist acted mainly to break excessively long silences, to draw out more passive members, to control monopolistic members, and to exert control over interactions which became too highly charged. Later in the initial phase, he was active in pointing out the resistance element in the silences and re-enactments of the marriage neuroses in the group.

THE PATIENTS AS THERAPISTS

As the group progressed, the members assumed more responsibility and took over some of the activities of the therapist, in addition to giving direct support and advice to each other. In controlling the hostile interchanges of the marriage neuroses, the therapist began to ask the group what was happening, and before long the group was able to respond to his cue and control the couple who were acting out at the moment. Later the group became able to control these outbursts without requiring a cue from the therapist. The group was also able to change its function from that of taking sides with the two partners in conflict to that of providing relatively impartial observations and judgments, which aided the reality testing of the conflicted partners and helped them individually to become aware of their involvement in the neurotic interaction. Patients also later tended to support and draw out members other than their own spouses. Rather than provoking jealousy on the part of the spouse, this usually seemed to induce a positive reaction in the partner, suggesting that the patient's spouse was identifying with the member to whom his partner was giving attention.

COMBINED THERAPY

Combined therapy seemed essential in the treatment of patients as sick as these group members under the conditions of heightened tension of this sort of group. The group experience aroused anxiety in and motivated certain of the members to the point where they could use individual therapy. Individual therapy, in turn, seemed to serve as a source of substitute gratification and ego identification which enabled members to tolerate the frustrations of the withholding mate in the group. All members at times expressed warm feelings toward their individual therapist as

being someone who was really interested in them and would listen to them. It seemed that having the individual therapist listen to them outside the group helped them gain the capacity to listen to their spouses in the group. Confessions of acting out and the expression of intense inner feelings tended to occur first in individual therapy and to appear later in the group. The presence of the individual therapist in the group as observer both provided support and exerted gentle pressure for bringing this material into the group. This factor seemed important enough so that when a second individual therapist began seeing some of the group members, he was also added to the group as an observer.

DISCUSSION

We agree with those authors who believe that intensive psychotherapy of married couples in a group not only is workable but also provides a specifically useful therapeutic procedure for dealing with disturbed marital interaction. Further criteria for the composition of such groups need to be worked out, but it is fair to conclude at this point that this group of couples with severe neurotic character disorders, who had reached a crisis in their marriages and had some motivation for working their problems out, could utilize this approach. We also need to learn more about transference and resistance factors in this, as compared to other types of groups.

CONCLUSIONS

1. An intensive psychotherapy group composed entirely of married couples is workable and therapeutically useful, within the limits of selection, methods, and goals outlined here.
2. The marriage neurosis appeared as the main form of resistance in the initial phase, and the principal work in that phase was resolution of this resistance.
3. Learning to control the marriage neurosis in the group was an ego-strengthening, corrective emotional experience.
4. The middle phase was reached when the patient's primary goal became that of solving his own problems rather than that of changing the marital partner.
5. Combined individual therapy was required to treat the members of this group adequately, and the group itself helped prepare less motivated members to accept individual therapy.
6. The re-establishment of free communication between marital partners was one of the major accomplishments of this group.

A SUGGESTED TREATMENT PLAN FOR THE HOSTILE ALCOHOLIC

EDWARD M. SCOTT, Ph.D.¹

Professional persons conversant with the literature on alcoholism are aware that complete elucidation of the alcoholic personality still remains to be achieved. Many reports, however, discuss basic personality factors in the alcoholic. There is no need here to review the literature on these two points, since many well-written summaries exist.

What appears necessary are better devised treatment plans for the alcoholic. Medical care for the alcoholic is adequately described in numerous reports in the literature, and new chemical agents continually appear. However, several authorities maintain that not drug therapy but psychotherapy is of more permanent assistance to the alcoholic. Strecker (1951) has stated that, "The basic treatment of pathological drinking should be largely psychological and re-educational and not pharmacological." But to a striking degree, there is little discussion as to specifics in the area of psychotherapy. Vogel (1958) writes about the intelligence and ego of the alcoholic, the assets of the therapist, "degree, duration and stage of alcoholism," and finally concludes that "the nonspecificity of present day treatment methods should not result in therapeutic nihilism."

It seems likely that, just as there are different types of schizophrenics, there are different types of alcoholics also. Granting this assumption, then, just as different methods of treatment are utilized in accordance with the type of schizophrenia, the same procedure ought to be employed with alcoholic patients. Yet, little recognition of this important factor has reached the literature.

Based upon eight years of experience, the present author is of the firm opinion that specific psychotherapeutic techniques are essential for the various alcoholic personality types. The type of alcoholic dealt with in this paper is, for want of a better term, called "the hostile alcoholic." Zwerling (1959) has stated that, based upon an intensive research project, "strikingly characteristic adaptive mechanisms and characterologic traits" exist in alcoholics. Five subgroups of alcoholics are described, one of which is the hostile alcoholic. He has failed, however, to distinguish between the passive-aggressive character and the aggressive type.

in his population sample the passive-aggressive type in the passive-aggressive category presented in the *Diagnostic and Statistical Manual* (1952)

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approaches the concept under discussion in that frustration with irritability and dependency are essential features, but also prominent in the hostile alcoholic are projection and sensitivity in interpersonal relations. The basic factors in the hostile alcoholic are: (1) angry outbursts, (2) constant projection, (3) extreme problems in interpersonal relations: a need for closeness, yet fear of closeness, (4) rejection, (5) narcissism, (6) unobtained goals, and (7) alcoholism.

In physical medicine, the recognition of a syndrome gives rise to attempts to discover a specific pharmacologic prescription. And in the area of psychotherapy, there is recognition that particular personality disorders often respond best to specific psychotherapeutic approaches. Wolberg (1954), for example, gives a series of suggestions in summary form. But in the realm of alcoholism, psychotherapeutic specifics are consistently lacking. Podolsky (1960) described the sociopathic alcoholic, but failed to suggest a treatment program. Wallerstein (1956) discussed a differential treatment program for alcoholics, employing disulfiram, conditioned-reflex therapy, and hypnotherapy. The over-all best result in his population was achieved with disulfiram. However, hypnotherapy was most successful with the passive-dependent alcoholic, while "... strongly aggressive patients pose comparable difficulties in whatever group assigned, with conditioned-reflex and hypnotherapy specifically contraindicated for different reasons."

STAGES AND PROBLEMS OF INVOLVEMENT

The therapeutic task is a difficult one when the patient is a hostile alcoholic, but the following plan has been found to be beneficial and the rate of success surprisingly high. In another paper (1961) the present author has outlined in general the technique of psychotherapy with the alcoholic. Appropriate modifications are here suggested for the hostile alcoholic.

Typically, the hostile alcoholic begins his first psychotherapy hour in an angry and frustrated manner. After the first few minutes, he quickly demonstrates his orientation of projection. Nearly always the rationalized cause of his problems is his wife. Typical statements are: "She's trying to destroy me," "She's always cutting me down," "I can't take it any more," etc. The patient is urged to continue his oral barrage by, "Tell me more about your wife." Near the conclusion of the first hour, however, reference is made to, "You have a problem with alcohol. Your temper also appears troublesome to you. Yet, you haven't talked about yourself. Next time try a little harder to do this." This is deliberately said at the end of the hour so as not to afford the patient time for a rebuttal.

At the second session, the patient usually begins by adding new in-

formation about his wife, principally concerning what took place during the past week. After a few minutes of listening, the therapist hands the patient some notes on hostility in which the basic dynamics are explained. The panel moderated by Weiss (1959), for example, serves this purpose. The notes are read over slowly, and the patient is asked to question any and all remarks. This stimulates some very defensive questioning on the patient's part. But a few therapeutic seeds have been planted. The patient will want to know again and again if the therapist thinks that he is hostile. An affirmative answer is given. This is threatening to the patient and he routinely presents an angry defense of his nonhostile attitude. He is then confronted with this phenomenon.

At the conclusion of the hour, the patient is asked to take the notes home, re-read them, and return with as many questions as he likes. Furthermore, he is invited to bring his wife to the next hour. The inclusion of the spouse is standard procedure with the present author (1959).

The ensuing therapy hour is a difficult one, either terminating in angry charges and countercharges or tearful and depressive reactions on the part of the wife. In the latter event, the therapist urges her to express herself, indicating that he will try to support her, while in the former, the following technique is employed.

Each spouse is instructed to address his or her remarks through the therapist. For example, "Doctor, will you tell my wife that she is entirely mistaken about how much I drink." The therapist relates this information to the wife, who in turn addresses her remarks to the therapist, saying: "Tell my husband that he's not fooling me. I know about his hidden bottles." This procedure is continued for fifteen or twenty minutes. Whether because the spouses realize the childishness of their remarks or whether "distance" (talking through the therapist) allows them more objectivity, typically they level off and can converse in a more adult fashion. Eventually, both want an evaluation from the therapist regarding the prospects: "Is there any hope?"

At this stage the present author introduces two ideas. One is that of group therapy. Group therapy is briefly explained. The couple is told that the group consists of husbands and wives who meet weekly for one and one half hours in the evening. Alcohol is the presenting problem for at least one spouse. In group therapy there is a free exchange among the members.

The second idea is that regular attendance gives the best hope for success. Examples are given of other couples faced with similar problems who have attended weekly and whose problems have been greatly reduced. Hence, they are told, the answer to their question is directly in their own hands. Motivation is the largest single problem in the treatment of the alcoholic, and the best criterion by which to judge motivation is regular

attendance. Fox and Smith (1959) have found that regular attendance is a "prominent feature" in successful treatment of the alcoholic.

Group therapy is the treatment of choice for the following reasons. First, the close relationships which of necessity develop in individual psychotherapy are avoided. The fear of close relationship is a constant pitfall for the hostile alcoholic. In group therapy the transference relationships are not so threatening. Second, the alcoholic's hostility is permitted to function, to a degree, and therefore his main defense is allowed to remain until other, more healthy defenses have been achieved.

In group therapy the hostile alcoholic quickly orients himself (about the second or third meeting) and begins to tell his story.

In a general discussion on group therapy and alcoholics, Feibel (1960) has stated that the alcoholic only gradually finds that it is not dangerous to express his aggressive impulses. While this is descriptive of the dependent or schizoid alcoholic, it is not applicable to the hostile alcoholic. He tells his story in an angry manner, and when interrupted by one of the group members, he heatedly demands, "Let me say what I have to say." When he is finished, the members begin to challenge many ingredients of his story, and it is at this early point that the hostile alcoholic comes face-to-face with a most painful situation. His temper erupts, he insists that he is misunderstood, and he makes angry charges of, "I can't see how this is helping me." When he attempts to talk about others, he is directed back to his own reactions, not those of his wife, business associates, or friends. Members point out that he acts threatened, that he behaves in a childish manner, that he is really angry at himself. This crucial session drains the whole group since it is so tense, but in the welter of confusion, a beginning is observed. The hostile alcoholic has been allowed to get angry, and some of the latent reasons for his anger begin to take shape.

But there are other significant problems yet to come. Often, the hostile alcoholic is clever at dividing the group. Some of the more timid members begin to agree with him, or he will challenge the very method of group therapy or demand certain fundamental changes in its procedure, and, of course, he is continuously attempting to defeat the therapist and at the same time seeking his approval. One of the essentials in such a situation is that the group have a "recovered" hostile alcoholic. This is most helpful because the recovered hostile alcoholic can contribute timely remarks which, because of their pointedness, are surprising and meaningful to the new member, as well as being hopeful omens for his own case. This is something the therapist cannot supply. On the other hand, the present author has found that simultaneous admission into the group of two new hostile alcoholic members is more than can be handled.

The hostile alcoholic is a perceptive individual, and when other mem-

bers discuss their own problems, he often remarks, "That's a superficial idea," or, "If that's all you can come up with, you'd better start all over." This keeps the group functioning at a deeper level and, as such, is helpful in the group therapy process.

The members have a "coffee-break" at the termination of the meeting. It has been found that this is a good method to stimulate relationships, to foster dynamics, and to produce a "working spirit." Gradually, noticeable changes begin to happen. The patient becomes chatty with some of the female group members. The following meeting he will make reference to, "Mary has a good idea," or some such remark. This is especially observable because the hostile alcoholic is still angry with his wife. This attempt at communication by the patient reveals an improvement in his development of interpersonal relationships. But the process is not a smooth one. Ordinarily the relationship develops too quickly, and when the female member fails to agree with some of his opinions, a cooling-off period ensues; then he strikes up a friendship with another female member. It is the author's opinion that the patient seeks a mother figure in his choices, since the life of the patient is typically that of a rejected child. Therefore, apparently, this must be worked through first. Coincidentally, the patient begins to release deep, hostile feelings against his mother which formerly he has denied. Hatred is still present toward the wife, and it has been found that attempts to bring about a more normal relationship should not be pushed too quickly.

INVOLVING THE SPOUSE

So far, little mention has been made of the hostile alcoholic's wife. My experience tends to indicate that the wives are passive, clinging individuals whose major object is to be a "good wife" and to establish a symbiotic relationship to the husband. This last factor is the most threatening element to the hostile alcoholic. Premaritally, the spouse-to-be perceived the patient to be a strong, determined man, one with whom her passivity could thrive, while the patient relaxed his defensive feelings, considering the bride to be a woman who could be manipulated and who appeared not too demanding. After marriage, instead of alleviating each other's neurotic condition, intensification occurred. The wife attempts in numerous ways to please her husband but receives only hurts, which she then suppresses.

In the conceptualization of Horney (1945) the wife has a neurotic need to move toward people, while the husband has a neurotic need to move against people. The wife must be assisted to express herself; and that, in fact, is one of the principal means of helping her husband. She should be urged to read, to chat with others, in short, to emerge from her dependent

cocoon. The emergence is a trying experience, but it is usually achieved. The wife becomes forthright in her statements during group therapy, openly expressing her feelings of anger, rejection, and frustration.

The relationship between the spouses undergoes some regressive features, and it is common for both of them to state that things are worse since coming to the clinic. Gradually, however, following the working through of hostility, growth makes sporadic appearances and periods of relative contentment are observed. The wife, as her resentments are released, feels less depressed, less tense, and more hopeful. She begins to react in a more adult manner. Even the patient acknowledges this. Typical comments by the wife are: "How could I have been so stupid," or "I just wouldn't have believed it," or, "I know I have a long way to go, but I already feel better." Little vignettes are reported. One wife related that, "My husband bought a car and I should have been happy, but I wasn't and I told him so. He didn't blow up. I just can't understand myself, but I now feel free to tell him how I feel and we can talk about our feelings."

FINAL STAGES

At this stage, the hostile alcoholic starts to make significant, insightful discoveries. One patient remarked, "I realize how rageful I was inside." The work of Seeman (1959) is appropriate at this point. In his experiments and reports of other investigations on personality integration, the concept of internal communication is paramount, namely, "the high-adjustment person facilitates receipt of information." The point being made in the present instance is that the hostile alcoholic finally attempts to receive, correctly, internal communication.

The above-mentioned patient reported the following dream. "I was a butler at a large house. Many guests were there. Suddenly a bunch of horses came running out of the surrounding valley, and all of a sudden they caught on fire. The people laughed. I was real angry." Analysis of the dream indicated that his inferiority was displayed by his position as a butler. The horses are male symbols, and it was he that was on fire. A bit of association revealed that the house was on a high hill, and then he suddenly stated, "It was my brother's house." As he continued, he recalled that the previous summer when visiting his brother (a highly successful medical man), the patient had been asked, "Are you going to make anything of yourself?" This dream and the ensuing sessions gave rise to a considerable amount of insight and subsequent working through and to a most important reduction in hostility. At subsequent meetings he would reflect, "So that's it. I'm rageful." He then would report meaningful episodes with new insight.

Another hostile alcoholic had tried AA, family counseling services, and individual counseling at the clinic, all without benefit. In the first interview, he expressed himself in a projective and snarling manner. When invited to bring his wife, following the second interview, he reluctantly consented. In the first joint interview, the wife felt that she "didn't have much to say," but, encouraged to express herself, she tearfully related her frustrations and feelings of rejection and hopelessness.

The couple was invited to attend group therapy. The group process was a long and difficult journey. The patient would angrily attack and then deny his obvious behavior. He was chronically distrustful and continually bracing himself against involvement with individual members as they attempted to "move toward" him. He engaged in a six-month feud with another male alcoholic patient, which irritated the group. Frequently he would demand a show of hands of those who "are on my side."

Then the patient became intensely interested in "what's really going on in group therapy." He became an avid reader about group therapy, and relentlessly forced the group to deep and more meaningful sessions. A feeling of confidence began to appear, and his hostile behavior started to subside. In the "coffee-break" after the meeting, it was quite noticeable that other members began to seek him out. Eventually the therapist administered a sociogram (though not for this reason) and the patient emerged as the best-liked member.

A formidable hurdle still remained, namely, the problem of the relationship between the spouses. The wife was a moderately withdrawn person who had been actively rejected in her early years. Within the first month of marriage, her husband showed that he preferred the beer parlor to her company. Confronted with rejection once again, she retreated and lived more to herself. The husband, the product of an alcoholic home and himself an unwanted child, harbored active resentment against women. He gradually admitted, "I'm afraid to get too close to my wife." By experiencing non-demanding and friendly relationships with female members of the group (mother substitutes were most often chosen), he became able to permit the demands of closer union with his spouse. As he verbalized, gained insight, and made little flights closer to his wife, he gradually began to drop his defensive structure. The wife, on her part, encouraged by the lifting of rejection, matched her husband's advance by emerging from her withdrawn state.

After three years of active, involved attendance in group therapy, the patient decided that he had received maximum benefit. Now, three years later, he continues to live without alcohol, his hostile behavior has significantly changed to mature self-assurance, and the family from all appearances is functioning at an adequate and happy level.

SUMMARY

Within the loose category of alcoholism, there is need for a specific psychotherapeutic treatment plan tailored to the type of alcoholic seeking help. The author has presented his concept of the hostile alcoholic and a plan for treatment which has been found to be helpful. The routine problems and dynamics encountered are described. Group therapy is the treatment of choice for a variety of reasons given in the body of the article.

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OBITUARY

Hassan Azima, M.D., a member of the Board of Directors of the American Group Psychotherapy Association, died at the Royal Victoria Hospital, Montreal, Canada, on June 25, 1962. On the staff of the Allan Memorial Institute of Psychiatry, Dr. Azima was also Associate Professor of Psychiatry at McGill University and Associate Psychiatrist at the Royal Victoria Hospital. His career was brilliant, and for a man 39 years old his accomplishments were distinguished.

Born in Teheran, Iran, in 1922, Dr. Azima earned his Bachelor of Arts degree at the University of California and proceeded to a medical degree at the University of Kansas in 1948. He also studied in Paris, where he obtained the Diploma in Psychiatry at the University of Paris in 1953. He then went to McGill University, where he attained first his Diploma in Psychiatry in 1955 and then his M.Sc. in Psychiatry a few years later.

In Paris, some of the theories which were to dominate his career had already engaged his attention. From the beginning, he was profoundly interested in the philosophical premises of psychiatry. At the same time, he was engrossed in the rapidly emerging field of psychopharmacology which was taking shape in Paris, and, at McGill, he founded one of the earliest sections in psychopharmacology. Throughout his brief, intensively active career these themes remained dominant.

With Jean Delay, Dr. Azima wrote on the subject of homeostasis in schizophrenia, and published papers dealing with consciousness and the body scheme in states of sensory limitation. He had an adventurous and inquiring mind and in the literary field there appeared many reports of special journeys into other fields: occupational therapy, neurophysiology, group therapy, anaclitic therapy, art therapy, and the projective techniques. His published scientific writings numbered eighty, and no less than ten books contained chapters which he wrote. At the time of death, he was preparing large-scale psychoanalytic research into regression and the understanding of interpretation.

An active participant in the American Group Psychotherapy Association, Dr. Azima frequently presented papers at the Annual Conferences, and he served as an instructor at the 1961 Institute. Prior to his death, he was engaged in the organization of an affiliate society of the Association in Montreal. Dr. Azima was elected to the Board of Directors of the Association, taking office in January 1962 and serving until the time of his death. The vacancy on the Board of Directors left by his death has been filled by the appointment of Mr. Arthur Eaton.

Dr. Azima's work was an inspiration to his colleagues, and his courage during the final stages of his illness won the admiration of all who knew him.

He is survived by his wife and two daughters.

LETTER TO THE EDITOR

To the Editor:

In the Volume XII, No. 3, July 1962 issue of the International Journal of Group Psychotherapy, page 347, there appears in the paper by Betty Berzon, entitled "Residual Parental Threat and Selective Interaction in Group Psychotherapy," a statement as follows: "... the therapeutic potency of the situation resides mainly in the interaction among group members (Hobbs, 1951; Moreno, 1945; Slavson, 1947)." I am not aware of the statements by Hobbs and Moreno in regard to this matter and have not been able to verify them in view of the fact that no reference is made in the bibliography to these two authors. However, reference is made to my *Introduction to Group Therapy* and *The Practice of Group Psychotherapy*. As is well known, my position is that all psychotherapy flows from the therapist even during the periods when he is remaining passive. The symbolic passive meaning of an adult in a role which is charismatically projected upon him by patients is the essence and the center of the therapeutic significance of the group.

Miss Berzon may have read some passages out of context in which, by implication, the statement she makes could have been construed; but she failed to realize that this referred only to activity group therapy with latency age children in which the therapist is required to remain predominantly inactive and no therapeutic interviews are held or interpretation given. This is quite different from typical analytic group psychotherapy with older young people and adults.

I am acquainted with Dr. Moreno's psychodramatic work and to the best of my understanding his work does not fall in the category of group psychotherapy insofar as there is no free interaction among the participants, the majority of whom are spectators, and the "seances" are directed by a "conductor" and auxiliary egos.

S. R. SLAVSON
New York, N. Y.

BOOK REVIEWS

Edited by BERYCE MacLENNAN, Ph.D.

PERCEPTUAL CHANGES IN PSYCHOPATHOLOGY. By William H. Ittelson and Samuel B. Kutash. New Brunswick, N. J.: Rutgers University Press, 1961, 262 pp., \$9.00.

In the field of psychotherapy, quantification systems to measure the processes taking place have been difficult to design. This is true of both group psychotherapy and of individual psychotherapy. This book deals with concepts in the area of visual perception which have been developed into measurable units. The concepts seem to offer the potential for effecting a measurement system in the field of group psychotherapy. Such a measurement system would be of help in achieving a better understanding of group processes and could also be of value in more precisely determining the direction and depth of the ongoing process of therapy at any given moment in time.

The book consists of a series of related papers on visual perception. They are by different authors and have been given unity by the editors. The particular mechanisms of visual perception used for the studies are judgments of figure sizes, "thereness-thatness" demonstrations, aniseikonic lens phenomena, and flicker fusion effects. The results obtained in the clinical use of these phenomena have in some experiments been correlated with data from conventional psychological testing devices (Rorschach, T.A.T., etc.). The experimental studies show how the perceptual properties involved may, in a given individual, be influenced by both environmental effects and intrapsychic forces.

From a theoretical standpoint two important premises are established here. First, perceptual flexibility, rather than perception per se, is the essential phenomenon studied in the experiments. In this way, detailed definitions of perception have been avoided—an undoubted simplifying device but perhaps leaving an area for further and useful development of the work. Second, the concept of perception used subsumes not only an awareness on the part of the subject of what is going on about him but also the conclusion drawn (defensive or otherwise) from this awareness. This seems to be a broader construct of perception than is ordinarily used.

The types of perceptual functioning represented are found to be significant dimensions of human behavior. Such studies as these are interesting and ingenious beginnings along potentially useful lines of inquiry. The approach used is in keeping with current trends to examine psychic mechanisms along functional and dynamic lines as opposed to purely static systems not immediately related to causal phenomena. While it is highly

specialized in content, this book should be of interest to those involved in experimental phases of the study of human behavior.

JOSEPH J. GELLER, M.D.
Ridgewood, N. J.

ANNUAL REVIEW OF PSYCHOLOGY, VOL. 13. Edited by *Paul R. Farnsworth, Olga McNemar, and Quinn McNemar*. Palo Alto: Annual Reviews, Inc., 1962, 602 pp., \$7.50.

Volume 13 differs but slightly from its predecessors, although chapters on mass communication and consumer analysis make their first appearance. For the third time, a chapter on the state of psychology in the U.S.S.R. is included. There are a total of 17 contributions.

For readers of this Journal, the chapter of primary interest may be Hans H. Strupp's on "Psychotherapy." The author has endeavored to abstract hundreds of sundry articles, in itself a monumental task, and has also delved into those trends in psychotherapy which he thinks are new. He finds that "what is encouraging is the increasing effort to identify meaningful research questions, to apply greater caution in conceptual analysis, and to plan more carefully before embarking on major research efforts." He divides his chapter into sections on "New Books and Edited Works" (among them only one "nontechnical" book on group psychotherapy), "Research Contributions," "Theoretical Contributions," and "Special Applications and Techniques." The bibliography contains 177 references, of which 25 pertain to group psychotherapy.

While it is not difficult to find fault with annual reviews (either in terms of conformity with previous volumes or lack of such conformity, either in being too comprehensive or too selective, too critical or too uncritical) it should be said that the Annual Review of Psychology in this, as in past volumes, has achieved an above-average level and can be highly recommended as a useful source of reference for psychologists and social scientists.

HANS A. ILLING
Los Angeles,
California

EDUCATING EMOTIONALLY DISTURBED CHILDREN. By *Norris G. Haring and E. Lakin Phillips*. New York: McGraw-Hill, 1962, 322 pp., \$6.50.

Drs. Haring and Phillips describe in some detail a school program for emotionally disturbed children carried on within the Arlington, Virginia, school system. The program is greatly indebted to Cruickshank's modification of Strauss's basic theory of work with brain-damaged children. Cruick-

shank has made intensive studies to determine whether the methods found useful with such children can be translated profitably to the emotionally disturbed, particularly to those banes of teachers' existence, the hyperactively disturbed.

Haring and Phillips studied three classroom groups of emotionally disturbed children, the determination of disturbance having been made by teachers' and school psychologists' observations and ratings. Class 3 was taught by a permissive teacher in a permissive atmosphere; class 2 by the ordinary classroom methods used in other unselected and larger classes. Class 1, the experimental group, was given a highly structured program with a highly structured teacher, cubicles to reduce distractability, ordered assignments, deprivation of play and free-time periods if work were not completed. Haring and Phillips believe their approach to be far more successful than those methods advanced either by child development or psychoanalytic or psychodynamic theory.

The results showing a higher gain in academic achievement appear on first glance to bear out their conclusions. These results, however, must be judged not on the basis of one method or philosophy over another since other significant factors were not controlled. *Only* the experimental group included close supervision and consultation with the teacher as part of the plan, and only the experimental group insisted upon monthly parent discussion meetings with the consultant and frequent individual meetings of parents with the teacher. These factors alone make such a tremendous difference that it is difficult to judge whether or not the understimulus, interference method, based on extinction of old patterns and rewards for new patterns, was the significant factor in improved performance. It is well established that when parents are willing to participate, the outlook is far more hopeful for the child regardless of the method of therapeutic intervention. Only those children with potentially cooperative parents were admitted to the experimental group since parent participation was considered essential. The growth of parents and of teacher through continued contact with and the help and support of the consultants invariably makes a great difference to the efficacy of any method. There is no longer any question concerning the workability of carefully thought out, developmentally sound tasks for emotionally disturbed children. Structure and clarity and thorough orientation limit confusion, reduce anxiety, and add to production. The particular task-oriented program is a reasonable extension of these ideas. Interference with nonperformance and reward for good performance are sound Pavlovian principles, but the subtleties of other factors operating for child, parent, and teacher are neglected in the results.

These results are good. Whether they treat the symptom and leave the disease to appear in different forms later remains a question. That these methods can be useful in larger school settings where individual treatment is not possible is unquestioned. Whether all forms of emotional

disturbance yield to such methods is debatable. The high structure and rigid planning seem to me to be well suited for impulsive, aggressive, acting-out children, or children in severe anxiety states, but I would wonder whether these same methods and use of materials are therapeutic for the withdrawn, repressed, phobic child. More work in differential diagnosis and treatment in educational settings would prove valuable in evaluating appropriate methods. It would seem to me that a more inclusive account of what happened here would yield a more accurate and more useful evaluation of this project.

The book makes a series of helpful suggestions, easily followed by school people. If it is taken as *one* step, or one way to facilitate the treatment and understanding of the emotionally disturbed child in his school life, it is a useful contribution to our present incomplete body of knowledge. Those people using it, however, should be aware that the highly structured method of teaching proposed, in itself, may not answer the central question of what does and what does not prove effective in working with emotionally disturbed children.

RUTH G. NEWMAN, PH.D.
Washington School of Psychiatry
Washington, D. C.

THE PSYCHOANALYTIC STUDY OF SOCIETY, VOL. I. Edited by Warner Muensterberger and Sidney Axelrad. New York: International Universities Press, 1960, 384 pp., \$7.50.

The stated aim of this annual is to provide a meeting between the work of the social scientist and the psychoanalyst. In our time, the importance of working toward a unified theory of human behavior is widely recognized. In the several branches of behavioral science, researchers are pushing their way into new spheres, cracking the traditional bounds of their particular specialties and invading their professional neighbor's territory. The old fences are breaking down, as is inevitable. This is the path of progress.

In reading the present volume, this writer had two kinds of reaction. In the main, the individual contributions are outstanding, but they do not yet, of themselves, offer the needed framework for the merging of a theory of personality and a theory of social systems. The main focus is on the relations between psychoanalysis and anthropology. Rather little of the technical side of sociology enters these discussions.

Volume I of *The Psychoanalytic Study of Society* offers a selected group of papers which take up special problems, among them ethnopsychiatry, creativity, and religion. Included, for example, are competent and insightful discussions of behavioral tendencies within a totalitarian system

(R. Waelder) and useful formulations in that intriguing sphere, the psychopathology of normal behavior (K. R. Eissler).

Says Eissler, the concept of health requires redefinition with each historical change and each successive phase of individual development. Correct. Then he suggests that health is a fictitious concept in the psychic realm. This is questionable. Since health is always relative and is a derivative of a shifting homeostatic balance, it is self-evident that the definition of health must shift with changing life conditions. To accept a relativistic view of health, however, does not by itself mean that there is no such thing.

But this is only one of many tantalizing questions stimulated by the rich handling of these open-ended problems of human behavior. This volume is profitable reading for all who strive to contribute to the building of a unified theory of human behavior.

NATHAN W. ACKERMAN, M.D.
New York, N. Y.

THE PSYCHOANALYTIC SITUATION: AN EXAMINATION OF ITS DEVELOPMENT AND ESSENTIAL NATURE. By *Leo Stone*. New York: International Universities Press, 1962, 160 pp., \$4.00.

This essay presents in highly condensed form a thoughtful, scholarly review of the "analytic situation," i.e., of the patient-therapist relationship and interaction in the form of psychotherapy known as psychoanalysis.

Stone points out that the psychoanalytic situation derives its power from the state of "deprivation in intimacy" or "intimate separation" in which it is carried out, with interaction mediated solely through speech. This represents to the unconscious the series of basic separation experiences in the child's relation to his mother, as, for example, in weaning. In contrast to this, the usual physician-patient relationship represents the early experiences of intimate bodily care by the mother. "This latent unconscious continuum-polarity facilitates the oscillation from 'psychosomatic' reactions and proximal archaic impulses and fantasies, up to the integration of impulse and fantasy life within the scope of the ego's control and activities. The latter state is largely contingent on the development of true integrated insight and its ancillary phenomena, as autonomous ego functions."

The author warns repeatedly against the twin perils of slavish, compulsive clinging to the letter of Freud's injunctions about the rule of abstinence, the emotionless approach like that of the surgeon, and the "mirror" model of the analyst, on the one hand, and the radical departure from these strictures, on the other hand. Stone cautiously navigates a middle course between this Scylla and Charybdis, and his own recommendations emerge as a reasonable application of Freud's three precepts, tempered with human warmth, flexibility, and common sense.

What results is no new breakthrough to an understanding of patient-therapist interaction. And, of course, this is not the intent of the book. What the book does provide is a review and illumination of the classical psychoanalytic formulations of the patient-therapist relationship, moderated by the long years of experience of a sensitive analyst—a review that may be read with pleasure and profit by analysts and nonanalysts alike.

The pleasure is somewhat marred by the needlessly complex style, the involuted sentence structure, and the excessive use of complicated technical terms when simpler words could express the meaning just as precisely and more understandably. This tends to hide the basic lucidity of the author's ideas, and often forces the reader to reread a sentence twice and three times to get its meaning.

This book, small though it is in size, represents a monumental amount of effort on the part of the author and will well reward the diligent reader.

I. ZIFERSTEIN, M.D.
Los Angeles, Calif.

MODERN CONCEPTS OF PSYCHOANALYSIS. By *Leon Salzman* and *Jules H. Masserman*. New York: Philosophical Library, 1962, 210 pp., \$4.75.

Psychoanalysis has advanced on many fronts as a theory of personality, as a method of research, as a dynamic approach to therapy, and as a professional and teaching institution ("my empire," as Freud called it). The great advances have had profound influence on philosophy, the social sciences, the humanities, and, finally, psychiatry. This book is an attempt to review and to integrate the progress made in these fields during the past fifty years.

Different authorities report on their special fields: Philosophy by John Reid; Sociology by Nolan D. C. Lewis; Anthropology by Ashley Montagu; Psychology by Carney Landis; Existential Philosophy by Harold Kelman. An especially thoughtful, original, stimulating, and well-written essay about science, behavior, and psychotherapy is contributed by Jurgen Ruesch, in which he discusses the assumptions that are made before therapy begins and elucidates the impasse that is reached when the art of mental healing is presented as a science of behavior. As soon as the investigator goes beyond the investigation of actions, speech sounds, or language codes, he becomes involved in meaning; and at that moment, he ceases to be a scientist: he changes from being an outside observer to becoming an inside participant. Psychiatrists could learn much from ethologists.

Edith Weigert writes a sensitive analysis of sympathy, empathy, and freedom in therapy. The changing faces of psychoanalytic training are described by John Millet in his usual straightforward, thoughtful, and courageous manner.

MARTIN GROTTJAHN, M.D.
Beverly Hills, Calif.

TROPICAL CHILDHOOD: CULTURAL TRANSMISSION AND LEARNING IN A RURAL PUERTO RICAN VILLAGE. By *David Landy*. Chapel Hill: University of North Carolina, 1959, 303 pp., \$6.00.

THE EIGHTH GENERATION: CULTURES AND PERSONALITIES OF NEW ORLEANS NEGROES. Edited by *John H. Rohrer* and *Munro S. Edmonson*. New York: Harpers, 1960, 357 pp., \$6.00.

Each of these books deals with interrelations between culture, social structure, and personality. In *Tropical Childhood* Landy describes child structure, and personality. In *Tropical Childhood* Landy describes child training practices and child behavior in the context of the culture and social structure of Valle Cana, a cane-dependent, rural community in Puerto Rico. The study was part of the Family Life Project sponsored by the Social Science Research Center of the University of Puerto Rico. During eight months of field work, data gathering included field observations as well as more structured techniques, not always habitual tools of cultural anthropologists: a census and community questionnaire, a structured interview with mothers, and doll play with children. Eighteen lower-class families were studied. The same interview schedules and rating scales were employed on two class groups in a New England community by Maccoby *et al.*, making it possible to compare the Puerto Rican and New England findings.

Landy first describes the culture and society of Valle Cana, then marriage and the family. Following this, he considers bringing up the child and coming of age. Finally, comparisons are made between Valle Cana and New England. The children about whom data were obtained were between four and seven so that the study deals with a relatively small segment of the life cycle. There is little emphasis on the socialization of adolescents or adults, or on nonfamilial agents of socialization—a delimitation which Landy makes clear. Descriptions of Valle Cana child training and child behavior and comparisons with the New England groups include infant feeding, toilet training, sex and modesty training, aggression, dependence and independence, sex-role typing, identification and superego. In a concluding chapter on "Culture, Childhood and Acculturation," Landy examines social changes in Valle Cana and the significance of the observed "loosely structured superego."

One might question whether the use of a comparable interview schedule under such radically different cultural settings would not unduly restrict the collection of data on issues crucial to the Vallecaneese themselves. Obtaining comparative categories which are meaningful within different cultures is a general scientific problem; but in this case the end result does not seem restricted. The number of cases is small, but careful attention is given to specifying limitations of the data where appropriate and the statistical material is interpreted in the context of field observations. The study represents the careful use of one type of comparative method.

In the *Eighth Generation*, Rohrer, Edmonson and, as co-authors, an

interdisciplinary team including a psychologist, an anthropologist, a sociologist, and two psychiatrists use another type of comparative method. Theirs is a follow-up study, after nearly twenty years, of a group of Negro individuals originally studied as adolescents by Davis and Dollard in *Children of Bondage* (1940). They attempted to relocate the individuals studied most intensively in the original study; of the 90 they traced, 47 were interviewed, and of these ten men and ten women were selected for more intensive psychological testing, observations in natural contexts at home and on the job, and psychiatric interviewing. A good deal of emphasis is placed on evaluating the accuracy of predictions in the earlier study. The case material is heavily weighted with psychological evaluations and levels of data and interpretation are not always distinct. As a result the book often lacks the immediacy of first-hand ethnography, but the life cycle scope makes it dramatic and fascinating.

The concept of "primary role identifications" is employed to analyze "the intimate interdependence of the social and psychological formation of identifications and of identity." The middle class, the matriarchy, the gang, the family, and "marginality" are examined as important sources of primary role identifications. The emphasis on nonfamilial agents of socialization is significant. The gang, for example, is examined as it furnishes male role models for boys who cannot find them in the matriarchy which is "emphatic in its exclusion of men." The authors claim that they were able to isolate a primary role identification for most individuals, that it was related to the quality of individual integration, and that certain identifications were characteristic of groups of individuals. In conclusion, the complexity of identification is emphasized, and the necessity is stressed of analyzing not one but several Negro cultures, personality types, and family types. The concept of primary role identifications is possibly an oversimplification, but it appears useful in ordering many of the intricacies of the data.

In rather different ways these two books approach questions of socialization and personality development, Landy through detailed examination of training and behavior in early childhood, Rohrer *et al.* through the study of life patterns of adolescents over a twenty-year period. The contrast in these two approaches, both important, is indicative of the complexity of achieving an adequate understanding of interconnections between the individual and his environment. Both books offer extremely valuable material for anyone concerned with these cultural groups. They offer illuminating examples of the range of family and personality structures which are possible under varying social conditions. Both merit the serious attention of anyone concerned with the interconnections of culture, social structure, and personality.

HOPE J. LEICHTER, PH.D.
Jewish Family Service
New York, N. Y.

HOMOSEXUALITY: A PSYCHOANALYTIC STUDY OF MALE HOMOSEXUALS. By Irving Bieber and Associates. New York: Basic Books, 1962, 366 pp., \$8.50.

This is a systematic study of 106 male homosexuals and 100 male heterosexuals used as controls. All the cases were in psychoanalytic treatment with members of the Society of Medical Psychoanalysts during a nine-year period of research and study beginning in 1952. These men were evaluated by means of a questionnaire of about 450 items as well as by inferential assessments of varied types.

The findings are discussed fully under separate categories; mother-son relationship; father-son relationship; siblings; the triangular system; developmental aspects of the prehomosexual child; homosexuality in adolescence; the sexual adaptation of the male homosexual; "latent" homosexuality; the results of treatment.

The authors conclude that fear of heterosexuality and castration anxiety related to female genitalia produce a homosexual adaptation. Heterosexual strivings were found to be acted out in homosexual relationships where the homosexual partner was identified with the mother and sisters. Reparative attempts to solve relationship problems originating with the father or brothers were made in the identification of the homosexual partner with a father or brother who was hated and feared.

The parents of the homosexuals had severe emotional problems, and each parent had a specific type of relationship with the homosexual son which did not occur with other siblings. The fathers were unusually hostile to men or sons and were perceived as sexual rivals. In about two-thirds of the cases the mother openly preferred her homosexual son to her husband and allied herself with him. When this occurred the father's hostility was increased and inhibited the son's own developing masculine sexuality. However, if the father were warm and constructively related to his son, the latter did not become homosexual even though the mother was seductive.

The homosexuals as a group began their sexual activity earlier than the heterosexuals and were more active sexually in pre-adolescence, probably due to maternal seductiveness. In their pre-adolescent and adolescent phases, the future homosexuals were isolates in over one-half of the cases and about one-third played primarily with girls.

With regard to treatment, the authors state, "In our judgment a heterosexual shift is a possibility for all homosexuals who are strongly motivated to change. We assume that heterosexuality is the biologic norm and that unless interfered with all individuals are heterosexual. Homosexuals do not bypass heterosexual developmental phases and all remain potentially heterosexual." They report a shift of 27 per cent from homosexuality to exclusive heterosexuality, and improvement in areas other than the sexual in a much higher percentage of the cases. Treatment was often sought

when deep depression followed the dissolution of a homosexual relationship.

Improvement in the sexual adjustment was greater in those cases that remained longest in treatment, in patients who were bisexual at the beginning of the analysis, who began treatment before age 35, who were not only children, who wanted to conceal their homosexuality, and who were well motivated. The sex of the psychoanalyst, the psychiatric diagnosis, and the theoretical orientation of the analyst had no influence on the prognosis.

This is an interesting study which emphasizes family relationships and endeavors to combine a clinical and a statistical approach.

SAMUEL FUTTERMAN, M.D.
Beverly Hills, Calif.

BOOKS RECEIVED

- THE PSYCHOANALYTIC STUDY OF SOCIETY, VOL. II. Edited by *Warner Muensterberger* and *Sidney Axelrad*. New York: International Universities Press, 1962 (\$7.50) 317 pages.
- CURRENT PSYCHIATRIC THERAPIES, VOL. II. Edited by *Jules H. Masserman*. New York: Grune & Stratton, 1962 (\$8.75) 300 pages.
- THE CRY FOR HELP. Edited by *Norman L. Farberow* and *Edwin S. Shneidman*. New York: McGraw-Hill, 1961 (\$9.95) 416 pages.
- PSYCHOLOGY OF SURVIVAL: HUMAN REACTIONS TO THE CATASTROPHES OF WAR. By *W. Von Greyerz*. New York: Elsevier, 1962 (\$3.75) 99 pages.
- PSYCHIATRISTS AS TEACHERS IN SCHOOLS OF SOCIAL WORK: REPORT No. 53. New York: Group for the Advancement of Psychiatry, 1962 (\$1.00) 51 pages (paperbound).
- THE COLLEGE EXPERIENCE: A FOCUS FOR PSYCHIATRIC RESEARCH REPORT No. 52. New York: Group for the Advancement of Psychiatry, 1962 (\$1.00) 47 pages (paperbound).
- MEDICAL USES OF HYPNOSIS: SYMPOSIUM No. 8. New York: Group for the Advancement of Psychiatry, 1962 (\$1.00) 60 pages (paperbound).
- FIVE ISSUES IN TRAINING. Edited by *Irving R. Weschler* and *Edgar H. Schein*. Washington, D.C.: National Training Laboratory, National Educational Association, 1962 (\$2.00) 128 pages (paperbound).
- PSYCHOTHERAPY IN THE SOVIET UNION. Edited by *Ralph B. Winn*. New York: Grove Press, 1962 (\$1.95) 216 pages (paperbound).
- INTERGROUP RELATIONS FOR POLICE OFFICERS. By *Charlotte Epstein*. Baltimore: Williams & Wilkins, 1962 (\$3.25) 203 pages (paperbound).
- THE EXPERIENCE OF REALITY IN CHILDHOOD SCHIZOPHRENIA. By *Austin M. Des Lauriers*. New York: International Universities Press, 1962 (\$5.00) 215 pages.
- COTTAGE SIX: THE SOCIAL SYSTEM OF DELINQUENT BOYS IN RESIDENTIAL TREATMENT. By *Howard W. Polsky*. New York: Russell Sage Foundation, 1962 (\$3.25) 193 pages.
- EGO SYNTHESIS IN DREAMS. By *Richard M. Jones*. Cambridge, Mass.: Schenkman, 1962 (\$2.45) 100 pages (paperbound).
- COLLEGE STUDENTS IN A MENTAL HOSPITAL. By *Carter C. Umbarger et al.* New York: Grune & Stratton, 1962 (\$5.75) 187 pages (paperbound).
- IDENTITY: MENTAL HEALTH AND VALUE SYSTEMS. Edited by *Kenneth Soddy*. Chicago: Quadrangle, 1962 (\$6.75) 283 pages.
- VIRGIN WIVES: A STUDY OF UNCONSUMMATED MARRIAGES. By *Leonard J. Friedman*. Springfield, Ill.: Charles C Thomas, 1962 (\$4.50) 174 pages.
- PSYCHIATRY AND THE CHRISTIAN. By *J. Dominian*. New York: Hawthorn, 1962 (\$3.50) 138 pages.
- THE AGE OF PSYCHOLOGY. By *Ernest Haveman*. New York: Grove, 1962 (50¢) 124 pages (paperbound).

- GOALS AND PROBLEMS OF TRAINING: THE ROLE OF GROUP PSYCHOTHERAPY IN A MENTAL HOSPITAL. By *Curt Boenheim*. Ohio: Columbus State Hospital, 1962, 55 pages (paperbound).
- PSYCHOANALYSIS AND PERSONALITY. By *Joseph Nuttin*. New York: The New American Library, 1962 (75¢) 332 pages (paperbound).
- THREE CONTRIBUTIONS TO THE THEORY OF SEX. By *Sigmund Freud*. New York: Dutton, 1962 (\$1.15) 124 pages (paperbound).
- HEAL THE HURT CHILD. By *Hertha Riese*. Chicago: University of Chicago Press, 1962 (\$8.50) 638 pages.
- CRIMINAL INTERROGATION AND CONFESSIONS. By *Fred E. Inbau* and *John E. Reid*. Baltimore: Williams & Wilkins, 1962 (\$6.50) 326 pages.
- KLINISCHE PSYCHOPATHOLOGIE. By *Kurt Schneider*. Stuttgart: Georg Thieme, 1962 (Dm. 16) 182 pages.
- DIRECT PSYCHOANALYTIC PSYCHIATRY. By *John N. Rosen*. New York: Grune & Stratton, 1962 (\$7.00) 271 pages.
- THE HEALTHY MIND IN COMMUNION AND COMMUNICATION. By *Robert T. Oliver* and *Dominick A. Barbara*. Springfield, Ill.: Charles C Thomas, 1962 (\$6.50) 177 pages.
- DIE TIEFENPSYCHOLOGISCHEN SCHULEN VON DEN ANFANGEN BIS ZUR GEGENWART. By *Dieter Wyss*. Göttingen: Vandenhoeck and Ruprecht, 1961, 433 pages.
- MATHEMATICAL METHODS IN SMALL GROUP PROCESSES. Edited by *Joan Criswell*, *Herbert Solomon* and *Patrick Suppes*. Stanford, Calif.: Stanford University Press, 1962, (\$9.75), 369 pages.
- AND A TIME TO DIE. By *Mark Pelgrin*. Sausalito, Calif.: Angel Island, 1962 (\$5.00) 160 pages.
- SOCIAL RESEARCH TO TEST IDEAS. By *Samuel A. Stouffer*. New York: Free Press of Glencoe, 1962 (\$8.50) 328 pages.
- THE OEDIPUS COMPLEX: CROSS CULTURAL EVIDENCE. By *William N. Stephens*. New York: Free Press of Glencoe, 1962 (\$6.00) 283 pages.
- IRRATIONAL DESPAIR: AN EXAMINATION OF EXISTENTIAL ANALYSIS. By *Benjamin Wolstein*. New York: Free Press of Glencoe, 1962, (\$6.00) 212 pages.
- CLINICAL PSYCHOLOGICAL CONSULTATION. By *Norman Tallent*. Englewood Cliffs, N.J.: Prentice-Hall, 1963 (\$8.65) 316 pages.
- THE PRECLINICAL TEACHING OF PSYCHIATRY: REPORT No. 54. New York: Group for the Advancement of Psychiatry (\$1.00) 62 pages (paperbound).
- THE PHENOMENA OF DEPRESSION. By *Roy R. Grinker, Sr.*, *Julian Miller*, *Melvin Sabshin*, *Robert Nunn*, *Jum C. Nunnally*. New York: Paul B. Hoeber, 1961 (\$6.50) 263 pages.

PROGRAM

TWENTIETH ANNUAL AGPA CONFERENCE
January 24-26, 1963
Mayflower Hotel
Connecticut Avenue at DeSales, Washington, D.C.

OPENING PLENARY SESSION

8:30 P.M., Thursday, January 24, 1963

Theme: **GROUP THERAPY IN ACTION FOR MENTAL HEALTH**
Chairman: MILTON M. BERGER, M.D.

THE SITUATIONAL PART OF DIAGNOSIS

JOHN C. WHITEHORN, M.D.

GROUP PSYCHOTHERAPY AND MENTAL HEALTH SOME IMPLICATIONS OF THE REPORT OF THE JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH

JACK R. EWALT, M.D.

Discussant: BERNARD F. REISS, Ph.D.

ALL-DAY PANEL MEETINGS

FRIDAY—9:30 A.M. TO 12 NOON
3:00 P.M. TO 5:30 P.M.

PANEL 1. THE THEORY AND PRACTICE OF ANALYTIC GROUP PSYCHOTHERAPY

Chairmen: S. R. SLAVSON and EMANUEL HALLOWITZ, M.S.

Morning Session

Chairman: S. R. SLAVSON

Principles of Analytic Group Psychotherapy with Adults,

JOSEPH J. PETERS, M.D.

A Study of Resistances, Their Sequence and Resolution in a Group Member, LESLIE ROSENTHAL.

Afternoon Session

Chairman: EMANUEL HALLOWITZ

Analytic Group Psychotherapy with Adolescents—Principles and Practices, S. R. SLAVSON

Group Psychotherapy of a Neurotic Boy with Suicidal Preoccupations,
NORMAN EPSTEIN

PANEL 2. THE RELATIONSHIP OF GROUP PSYCHOTHERAPY TO GROUP DYNAMICS

Chairmen: LEWIS H. LOESSER, M.D., and MORRIS B. PARLOFF, PH.D.

Morning Session

Position Paper: Field of Group Psychotherapy, ELVIN V. SEMIRAD, M.D.

Position Paper: Field of Group Dynamics, HERBERT C. KELMAN, PH.D.

Discussants: JOHN R. P. FRENCH, PH.D., HERBERT S. COFFEY, PH.D.,
WARREN G. BENNIS, PH.D., THEODORE MILLS, PH.D., JEROME D.
FRANK, M.D., SAUL SCHEIDLINGER, PH.D., and HARRIS B. PECK, M.D.

PANEL 3. GROUP THERAPY AND GROUP PROCESSES IN PSYCHIATRIC HOSPITAL AND OUTPATIENT SETTINGS

Chairmen: SAMUEL B. KUTASH, PH.D., and JOHN J. BLASKO, M.D.

Morning Session

Chairman: JOHN J. BLASKO, M.D.

Opening Remarks, WILLIAM S. MIDDLETON, M.D.

Some Observations on the Impact of Group Therapy on the Therapist,
MARY V. MCINDOO, M.D.

A Psychologist's Role in a Small Group Plan of Patient Care,
EARL G. GUYER, PH.D.

Group Therapy in the Psychiatric Hospital—Current Practices and Problems, JOSEPH ABRAHAMS, M.D.

Afternoon Session

Chairman: SAMUEL B. KUTASH, PH.D.

Practical Problems in Clinic Group Psychotherapy, MAURICE LORR, PH.D.

WORKSHOP MEETINGS

FRIDAY—9:30 A.M. TO 12:00 NOON

WORKSHOP 1. SUPERVISION OF GROUP THERAPISTS

Chairmen: HELEN E. DURKIN, PH.D., JOSEPH J. GELLER, M.D., and SIDNEY LEVIN, M.D.

WORKSHOP 2. ORGANIZATIONAL PROBLEMS IN SETTING UP GROUP THERAPY PROGRAMS IN MENTAL HYGIENE CLINICS

Chairmen: MARVIN L. ARONSON, PH.D., and JOSEPH B. MARGOLIN, PH.D.

WORKSHOP 3. MARRIED COUPLES IN GROUP THERAPY

Chairmen: DANICA DEUTSCH and GEORGE P. FANNING

GROUP PSYCHOTHERAPY FILMS

Sponsored by the Audio-Visual Aids Committee

FRIDAY—9:30 A.M. to 12:00 NOON

Chairman: ASYA L. KADIS

Film: The Road to Reality

Discussant: RICHARD G. ABELL, M.D.

Film: Activity Group Therapy

Discussant: MORTIMER SCHIFFER, M.S.

SECTION MEETINGS

FRIDAY—9:30 A.M. to 12:00 NOON

SECTION I

Chairman: ROBERT A. YOUNG, Ed.D.

1. Comparison Between Short-Term Group and Individual Psychotherapy in Effecting Change in Undesirable Behavior in Children, JACK I. NOVICK, Ph.D.
2. An Exploration of the "Small Room" Technique in Group Psychotherapy with the Latency Child, DORIS KRAEMER, Ph.D., and SYDNEY BROWN, M.S.
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Resource Person: MILTON KALIN, M.S.

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SPECIAL VALUES OF CO-THERAPISTS IN GROUP PSYCHOTHERAPY

ELIZABETH E. MINTZ, Ph.D.¹

Elsewhere, this writer (Mintz, 1963) has reviewed relevant literature and discussed special transference phenomena in groups led jointly by a man and woman as co-therapists, comparing them to groups led by a single therapist or by two therapists of the same sex. Among the advantages of co-therapists are: that in combining their insights, technical abilities, and other assets, two therapists may offer more to the group than either could offer alone; that a situation close to the primary family is created, providing patients an especially good chance to work out transference reactions toward both parent figures and deal with fantasies about the parental relationship; that patients of both sexes are offered a like-sexed therapist with whom to identify; and that special difficulties in relating to either male or female authority figures can be worked through by patients who would have been unwilling to choose a therapist of the more threatening sex. For many therapists, this way of working also has the personal value of constituting a two-way learning situation between peers and of alleviating the isolation of private practice.

This paper deals further with a particular aspect of transference in co-therapy groups: that often a patient relates to one therapist with relative consistency, perceiving him with minimal distortion, while working through a series of vehement, irrational, and often dramatic transference reactions to the other therapist. It appears that one therapist can be selected to represent the reality principle, allowing the patient to give fantasy reactions free play with the other therapist. A stable relationship with one therapist seems to provide a framework, or a safe anchorage, permitting the patient to feel and explore violent reactions which under other circumstances might be restrained through fear of a complete break with reality.

The material presented is drawn from the writer's four years of experience with three co-therapists² in private practice. Co-leadership was on a peer basis. Groups were composed of adult neurotic or borderline patients drawn from the practices of both therapists. Typically, patients were placed in groups after a period of psychoanalytically oriented individual therapy, and usually continued to have individual sessions with the therapist who brought them into the group.

¹ Faculty, National Psychological Association for Psychoanalysis, New York, N. Y.

² Grateful acknowledgement is due to Drs. Samuel Shrut, Thomas E. Tierney, and Murray List.

Case I

Liane was a woman whose acceptance and enjoyment of femininity appeared, in the latter phase of treatment, to be considerably facilitated by the co-therapy situation. Liane had entered treatment in her early thirties with a male therapist who described her as "hating herself and the world, full of bitterness and scorn" at the beginning of treatment. Her manner and appearance, which was strikingly handsome, were hard and masculine. She engaged in promiscuous sex activity with both men and women. Consciously she loved but despised her father, hated and resented her mother. But she continually sought childish pseudosexual satisfactions with older women, whom she bribed to cuddle and comfort her by offering them skillful physical gratification. Here, it seems safe to infer, appeared the return of a repressed wish for the motherly love she consciously rejected.

In treatment with her male therapist, Liane became considerably happier and more self-accepting. She worked out her hatred and envy of men in the transference, and for the first time formed a stable love relationship, with a man who realistically could not marry her because of outside circumstances. Homosexual relationships ceased, but she could still not enjoy friendships with women, presumably because a pathological attitude toward them persisted.

For two years Liane attended a group conducted by her male therapist alone. She had been the group's dominant woman member and had never developed a mother-transference toward anyone. Through co-therapy, her therapist hoped that she could work out the remaining problems which derived from her relationship to her mother.

In view of Liane's own awareness of why co-therapy had been recommended to her, the vividness of her initial reaction to me was particularly striking. From the moment she first walked into the group therapy room, Liane hated me. For two sessions she maintained a haughty silence. Then in the third session she spoke for the first time, informing me of her "terrible disappointment." She had hoped that I would be the longed-for, ideal mother—"beautiful, brilliant, well-groomed, witty"—but I was the exact opposite and so she was disappointed and disgusted. "And yet," she said, "I somehow feel that you have something to give me, and I want it."

Without interpretation, I attempted to convey acceptance of her feelings. In the next session, with great feeling, Liane said that after the last group she had been alone in her apartment and had found herself weeping like a child. As if to her mother, she had cried aloud, "Why don't you let me love you? If only you would let me love you!" These feelings had astonished her, since she had thought that she no longer felt anything except distaste and resentment for her mother, who lived in another part of the country and whom Liane saw very rarely. She could recall little from her childhood except nagging, scolding, rejection, and excessive demands. Now she remembered how she had longed to express affection for her mother.

Looking directly at me, she said, "It is more important for you to let *me* love *you* than for *you* to love *me*."

This insight seemed correct. Nearing forty, and not psychotic, she had no need of mother-love in therapy, but she did need to work out why she was afraid to care about a woman. If the repressed tenderness toward her mother could emerge, and if she could accept whatever had been good in their relationship, she might be able to enjoy friendships with women and also to enjoy her own womanhood more fully.

Soon thereafter Liane began to evoke as defenses the negative feelings she had once experienced toward her mother. She said that now she was afraid of me. My glasses concealed my face, making my expression unreadable, and so she could not protect herself against unexpected attacks from me. Like her mother, I would always know mysteriously when she was doing something wrong and I would punish her. When I seemed friendly, it was only to conceal my viciousness.

After a few sessions during which Liane remained withdrawn, the warm feelings returned. She told of a fantasy in which she would live with me, sleep with me, be cared for, in an ideal mother-baby relationship. She also said she felt that she "could make me very happy" sexually. It was a repetition of her old pattern of bribing a woman to mother her by offering sexuality. Yet there was nothing really seductive in her manner; rather, it was the intense longing for a good mother. Around this time, group members commented on how much softer Liane's face began to look and on the disappearance of the slight, hard edge of masculinity in her manner.

A few months later, Liane announced to the group that she had been thinking carefully about me, had ascertained that I had children, and now wished to see me once a week in addition to continuing her regular individual sessions with her male therapist. She said again that the great value was in being permitted to love me. Her longing for a mystical reunion with her mother, the "oceanic" feeling, emerged with great intensity and depth. I tried to convey an understanding of her feelings, while explaining that a mystical reunion was not possible. Taking a more interpretative role, my colleague stressed Liane's need to separate her parents, now appearing as an unrecognized wish to play the two therapists against each other.

With this Liane gave up her effort to arrange individual sessions with me, and soon began to work differently in the group. She treated the therapists as partners working together to help her and she showed more interest in other group members. She continued to appear to other group members as increasingly soft and feminine, and she reported that she and her lover found their relationship more rewarding.

Dynamically, what had happened? Through her series of transference reactions to me, Liane understood that her rejection of her mother covered a need to receive love and an even greater need to give it. Not for the first time, but with deepened feeling, she saw that in the past she had tried

through homosexuality to reach her mother. On a deeper level, Liane's acceptance of me helped her to accept herself. If, as her transference-mother, I could be a woman without being vicious as her mother had appeared to be, then Liane could also be a woman without seeing herself as vicious. At the same time, I represented reality in helping Liane see the impossibility of a mystical mother-baby relationship. Finally, although Liane's spoken remarks in the group did not support this as they support the other inferences, it seems probable that in accepting the two of us as co-therapists rather than rivals, she was helped to integrate the masculine and feminine aspects of her own personality.

As with other cases, both therapists thought that all this material could have been dealt with eventually in Liane's treatment with her male therapist but that it probably would have taken longer and had less emotional depth. Rapid, intense transference reactions such as these are most likely to appear in co-therapy groups (1) when the patient has originally chosen a therapist of the sex less feared; (2) when there has been a period of intensive treatment with the first therapist; and (3) when the first therapist has clarified transference reactions thoroughly enough so that the patient can use the first therapist as a stable reality figure while allowing intense transference to the co-therapist to develop.

Case II

Don also used one therapist as a stable reality figure who offered the security of a fairly realistic relationship. With the other therapist, Don worked out a series of transference reactions corresponding to the various levels of defense against a primitive oedipal fear of his father.

Don had been in analytic treatment with me for about four years when I offered him membership in a co-therapy group. At the beginning of treatment he had been severely neurotic or perhaps even borderline, with almost no sense of personal identity, so accustomed to constant anxiety and guilt that he hardly regarded these feelings as symptoms. He was a very talented artist who had received some recognition but was almost totally unable to work. He was exclusively homosexual, promiscuous, disliked his way of life, but hoped for nothing better. He had chosen a woman analyst on the assumption that treatment would be "less formal and austere" than with a man, though he recognized only years later that heterosexual men frightened him at least as much as women did.

After four years of treatment, Don's work block was gone and he was advancing steadily in his profession; he felt well much of the time and sometimes very well; such symptoms as insomnia and suicidal impulses were relieved; but he was still entirely homosexual. Nor had Don been able to work out the effects of his relationship to his father. He still saw his mother as the only meaningful parent, and had worked out in the trans-

ference to me many of the difficulties which had arisen through his dependent, sensual relationship to her. But the father remained shadowy and almost meaningless.

To help Don work out these remaining problems I might have referred him to a man to finish his analysis, first working out with him the sense of rejection he would have felt, but this course would have sacrificed the mutual respect and rapport, and my understanding of him, which had been built up through the years. Fortunately, I was able to place Don in a co-therapy group instead.

Don now went through a sequence of responses to my male colleague which, in reverse order, represented the chronological stages of defensive attitudes toward his father. First, he saw the male therapist as cold and impassive, exactly as he recalled his father. Don was indifferent to him, though involved with group members, as he had been indifferent to his father.

Next, Don began to feel that my colleague despised him for homosexuality, as he felt his father had despised him for effeminacy in boyhood. Although Don was now generally confident, he felt like a helpless child with the male therapist.

Now came a deeper kind of transference response, corresponding to an earlier chronological age. Don was attracted to a woman in the group and anticipated that the male therapist would rebuke him. He could now see with emotional meaning, not merely with intellectual realization, that a fear of his father still prevented him from expressing sexual impulses toward women, which now seemed more intense and also more natural than ever before. He felt that his male therapist might explode in violent rage if Don asserted himself as a male in the group, and for the first time he recalled that he had always suspected potential violence in his father's detached personality. He could see that the real personality of the male therapist was not responsible for these reactions, which therefore must come from the past. With little interpretative help, he saw that he was now continuing a homosexual way of life in part because he was afraid of being punished by his father, the father who until recently had seemed a meaningless shadow-figure. He saw that homosexuality was not fated, but depended on his own choice. He felt well generally, but decided to continue treatment until he could make a sexual adjustment which would really satisfy him.

Thus we see that co-therapy may offer a natural opportunity to work out feelings derived from early relationships with the more-feared parent, without sacrificing the current relationship with the analyst originally chosen as a representative of the sex less feared.

As further examples of striking transference manifestations in co-therapy groups, here are cited three women patients who perceived me not

as a maternal transference figure but as an *unaccepted part of the self*. These extremely varied descriptions of me were all made within the first few sessions.

Case III was an unmarried woman of 30 whose intelligence was apparently far superior to that of the rest of her family. She seemed to have decided that an air of frivolity and light-mindedness was the only road to acceptance. Group members noted her continual pointless laughter, which was not schizophrenic inappropriateness but a neurotic character defense with which the patient was unconsciously displeased and which she therefore projected. About me, she said, "She laughs all the time or just sits there with that silly smile. She is a dizzy dame. She's silly. I don't see how she got her Ph.D. I bet she got it being cute at the profs."

The same mechanism appeared in another woman, Case IV, who in her first group sessions presented herself as warm, feminine, and very shy. Almost at once the group saw this as a pretense, and soon had the patient declaring openly and with great vehemence that she had always wished to be a man. Before admitting this, the patient said of me, "She is an analyst because she can't find a husband and have children. She has no femininity. I can't imagine her in a frilly nightgown. . . . Do you ever use perfume? . . . She *tries* to dress badly. She acts so cold and superior all the time." Here again, an underlying desire, not unconscious but not accepted, was projected on the female therapist.

Case V, a girl in her early twenties, very pretty but drably dressed and not made up, left treatment before she could be understood. But both therapists thought that her drabness was incongruous with her prettiness and youth and that she was rejecting in me the same femininity that she rejected in herself. She said, "I think it's terrible for an analyst to wear such a red dress and lipstick. She ought to be dignified."

These examples suggest that transference feeling may arise in co-therapy groups with a readiness and an intensity beyond that usually evoked in conventional groups or individual therapy. This is a rich field in which to explore how, and to what extent, the efficacy of therapy is related to the vicissitudes of transference. From research and clinical observations in co-therapy, we may learn much about the way in which personality develops in relationships with the two parents; the effect of the therapist's actual personality on transference and hence on the entire psychotherapeutic process; and a better understanding of the transference phenomenon itself.

REFERENCE

- Mintz, E. E. (1963), *Transference in Co-Therapy Groups*. *J. Consult. Psychol.* (In press.)

GROUP PSYCHOTHERAPY WITH FATHER AND SON AS CO-THERAPISTS: SOME DYNAMIC CONSIDERATIONS

JOSEPH C. SOLOMON, M.D.,¹ and GEORGE F. SOLOMON, M.D.²

This presentation will discuss the unique aspects of the operation of father and son as co-therapists in a group psychotherapy situation. For a year and a half prior to a two-year interruption during the junior therapist's military service and for fifteen months since his return, we have worked with from four to eight intelligent, well-educated, predominantly professional adults of both sexes, most of whom have had considerable psychoanalysis and have continued in individual therapy with the senior therapist. During the junior therapist's absence he was frequently mentioned by members of the group, including those who did not know him; thus, to a degree, he continued to serve as a transference figure even in absentia. Patients selected were those with whom group work was felt to be a useful therapeutic adjunct on the basis of its opportunity to engage in and explore real interpersonal experience. There has been a complete turnover from the original group, the duration of group work averaging over a year. No attempt has been made toward psychopathological homogeneity, and patients have varied from the withdrawn to the flamboyant, from those with large areas of intact ego function to a few with somewhat impaired reality testing, from those with predominantly symptomatic to those with essentially characterological problems. Sessions are of two hours' duration, held one evening a week. As an explicit design, the junior therapist has no knowledge of the patients other than is revealed within the group, allowing his freedom of reaction to group process apart from contamination of information and impressions from individual therapy. No effort will be made to discuss those aspects of the therapeutic process resembling those of any other psychoanalytically oriented two-leader group; rather, we shall concentrate on the particular uniqueness of the father-son team.

OPERATIONAL APPROACH

Each therapist felt free to offer whatever comment, interpretation or intervention he deemed suitable within the group. Though there may have

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been theoretical discussion between them outside the group, there was a genuine lack of overt or implied criticism. Any differences were accepted and not seen as evidence of hostility or power struggle. Both therapists focused upon analysis of group transaction, transference, and resistance, but often commented on intrapsychic dynamics. Similar interpretations made independently may reinforce impact upon patients; whereas, comments of different slant may encourage a new approach to a problem. At times patients found it difficult to realize that the junior therapist's comments were spontaneous, his own and solely based upon observation from within the group. Such freedom of the therapists, indeed, provided an atmosphere conducive toward expressivity on the part of the group members. Only on one occasion could a countertransference reaction clearly be delineated. The junior therapist minimized an intercurrent illness of the senior and directed discussion away from the topic. At a later group meeting, the therapists discussed and acknowledged this reaction as a defensive manifestation of anxious concern.

The group situation is a remarkable crucible for the testing out and working through of interpersonal modes in a living experiment. There is the opportunity to demonstrate relationships with both historically and currently significant persons through multiple transferences within the group. Inasmuch as sibling rivalry is a crucial psychodynamic determinant with many psychoneurotic individuals, as an original rationale, it seemed captivating to have an actual sibling equivalent in a leadership position. Furthermore, it was felt that the demonstration of a real harmonious parent-child relationship as adult to adult would serve as a model for the establishment of similar relationships by identification.

We cannot say whether others would have the same experience, but we do feel that ours has been an effective working relationship that has often yielded salutary results with patients. Reactions of individual patients to the father-son situation has tended to be idiosyncratic as based upon personal psychopathology. A few reactions will be delineated.

IDENTIFICATION WITH THE VICTIM

On several occasions, especially during individual sessions, patients have put themselves in the position of the junior therapist and imagined the feelings that he must be experiencing during the group meetings. One patient said, "I bet you bawl the hell out of him when he makes some wrong comment." Another said, "I guess Dr. George tries very hard to do the right thing so you won't get mad at him."

One male patient was particularly vocal about projecting his own anxieties on the junior therapist. He spoke up in the group many times, "I don't

see how Dr. George can stand it working so close with his father!" This patient then was able to relate how uncomfortable he felt in the presence of his father. Previously, in individual therapy, the patient had always spoken of his lack of conflict with his father. He had considered him a "good guy." It was his mother who had given him difficulty. It was she to whom he had expressed open and unabated hostility. By recognizing some of his fears of his father with the attendant imageries of castration, he was able to see that his concern for the junior therapist stemmed from within himself. This realization laid the groundwork for his later understanding that in life he was creating war-like situations and that he harbored many hostile, castrative thoughts toward his father, which he had displaced onto his mother.

DISPLACEMENT OF AGGRESSION

While there often seemed inhibition in expressing hostility to the senior therapist, there has been a great deal less control in displaying such feelings toward the junior therapist. Often these aggressive attitudes were revealed in the individual hours, even when they were not overtly manifested in the group sessions. There was little doubt that this hostility frequently represented an oblique attack upon the father figure, both indirectly through the actual relationship and as a result of simple displacement as a dynamic maneuver. "I don't know why I feel so enraged at Dr. George"; "It gets me furious every time he says something"; "I try not to listen when he talks"; "I resent his being there" are examples of such hostile comments. Often these attacks were masked by rationalizations and spurious reasoning, but their intent was open to no doubt. Needless to say, such reactions furnished added material for work in the individual sessions as well as supplying emotional grist for the mill of the group interaction. The stakes involved in attacking the junior therapist are less than are involved in attacking the senior therapist. The implications of the fear of the consequences, such as loss of esteem, fear of rejection or other forms of retaliation are obvious. The same displacement was evident in attacks upon the wife of the junior therapist rather than upon the wife of the senior therapist.

DISPLACEMENT OF LIBIDO

Just as aggressive impulses may have been displaced from one therapist to the other, the erotic impulses sometimes have been similarly displaced. Guilt feelings attendant with libidinal feelings to the senior therapist were more easily handled when the fantasies involved the son rather than the father. This, moreover, was a device to avoid the clear-cut incest fantasies involving the parental image. Erotic feelings involving the son

had a semblance of reality, which gave release to the oedipal feelings and simultaneously bypassed the superego.

These displacements were brought clearly into focus by one female patient, whose fantasies transcended the sphere of reality to such a degree that she required hospitalization. The severity of her disturbance did not become evident until the erotic fantasies were manifest. An exception, this patient was not in individual therapy, though her husband was. She was the only patient in whom group work catalyzed unwholesome regression. She developed the idea that the senior therapist wanted her to divorce her husband and marry his son. She conceived the idea that the father-son therapy was designed for her to fall in love with the junior therapist. Out of this she wove a whole web of projections and irrational deductions that drew her further and further away from an understanding of her real oedipal conflicts. During and after her hospitalization she was treated by other therapists. She subsequently divorced her husband, something she wanted to do in the first place.

TRANSFER OF DISTANCE

In several instances it was noteworthy that the patients had no feeling whatsoever of the relationship of the two therapists to each other. They reacted to the therapists as separate individuals without any apparent awareness of the real family ties. Even when this fact was mentioned, one woman said, "I see you both as separate people and react to each of you accordingly." One factor in the establishment of the distance between the two therapists was the need for these patients to deny the fact of the relationship of father to son because they, too, would have liked to be the senior's children but could not be; hence, they could not accept anyone else in this role.

A second factor was the actual transfer of distance. This phenomenon occurred with patients who had such distant feelings about their own parents that they were unable to conceive of any other type of parent-child relationship. One patient said, "I don't know what the other people in the group make such a fuss about when they talk about parents. I never felt close to either parent; so I can't feel close to anyone, nor do I expect anyone to be close to anyone else."

A third factor in the concept of distance between the two therapists was the denial of the relationship in order to unleash aggression against one or the other of the therapists. One patient said, "How can I feel free to attack Dr. George if I am aware that he is your son? You will come to his defense, and where will that leave me?"

OTHER TRANSFERENCE PHENOMENA

When one therapist was absent for an occasional single session, some patients became particularly verbal and expressive of affect. In the absence of the senior therapist, at times "the mice played while the cat was away," free of control of the projectively punitive parent. In the absence of the junior therapist, some patients felt gleeful at the elimination of the fantasied rival, while others felt inhibited as a result of disruption of the "family circle." On occasion, the junior therapist was effective as a result of being free at the moment of transferred affects, so that his interpretations of resistances and transference not involving himself could better be attended to. Such an intervention during the senior's absence on vacation seemed to lead to a break in an impasse in a patient's personal psychoanalysis, followed by its relatively prompt and successful termination. Another such example is that of the dependent, infantile man, who previously had been in individual treatment with the senior therapist and joined the group without concurrent individual work in the face of difficulties in his recent second marriage. The group encouraged him to undertake further individual work, which he subsequently did with the junior therapist. He was promptly able to deal with material that never had come up in his previous psychotherapy. "I need so much for your father to like me, I could never tell him these things. I don't like you nearly so well; so it doesn't matter." Positive transference had served as a resistance. This patient had never really finished mourning his father, who had died several years previously. He always had longed for his largely absent and indifferent father's love as a result of a very unsatisfactory relationship with his mother. It is of note that only after his repressed grief broke through explosively in a group meeting in response to discussion of father and son relationships, did he follow the suggestion to seek further individual work.

One woman patient, though acknowledging resentment of the father-son dyad, expressed gratification that the father deigned to relate to other members of the group. Her father and younger brother had an intense relationship, from which she hurtfully felt completely excluded. She had tried unsuccessfully to break in by acting like a boy. This same patient reported several other specific reactions. She distrusted the junior therapist because her sacrosanct brother served as an agent of the parents, whose bidding he got the patient to do. Rather uniquely, she felt freer to direct hostility to the senior therapist than to the junior, representing the brother, for attacking whom she would have been severely chastised. She perceived the junior therapist as fragile and prone to injury and destruction by attack. She felt

the junior therapist as more "real" than the senior, however, the adult world being seen as a separate orbit, foreign, mysterious and magical. To her, the childhood world seemed straightforward, logical and understandable. She projected her magical fantasies onto adults. In another vein, this patient reacted to the actual father-son relationship positively. "I feel better able to have pride in my own son without guilt and without a sense of being narcissistic like parents who gloat over the accomplishments of 'a chip off the old block.'"

A different patient did not extrapolate the father-son relationship to the exclusive dyad of her mother and sister. She commented that though their mannerisms were remarkably similar, both therapists seemed individual personalities and did not leave her out. Another patient felt reassured by the similarities between the therapists. During a vacation of the senior, she requested an individual session with the junior because of a current crisis. She later reported to the group the sense of validation she found in his approaching the problem in a manner similar to the way she perceived his father would have.

INTROJECTION OF HARMONY

One of the most salutary features of the father-son therapeutic leadership was the example that was set of the continuous harmonious relationship of the therapists. There was no need to postulate the concept that a parent can get along with his offspring. This was a living demonstration that brooked no argument. It did not require any explanation but served as an actual perceptual experience that was genuine and sincere. No patient ever questioned the truly harmonious aspect of the relationship, nor were there any accusations of artificiality or dramatization.

More than one patient remarked, "I can see you are proud when Dr. George makes a worthwhile comment." Other patients saw the situation from the junior therapist's point of view. "Dr. George is fortunate to have a dad who helps him develop the skills of his profession."

Heartened by the participation in the live situation of the harmony between the two generations, the patients brought some of this atmosphere into their homes. There was afforded the opportunity for internalizing the predictability of the smoothly working relationship of father and son as a replacement for the formerly introjected turmoil of their respective childhoods.

Identification occurred in several ways. Whether it was identification by imitation out of admiration for one or both of the principals, whether it was identification by substitution as an outgrowth of hostility and replace-

ment or whether for other reasons, this phenomenon occurred in group as well as individual therapy. If the patient identified with either the junior or senior therapist, it eventually led to the identification with the relationship that existed between the father-son team.

AMALGAMATION AND INDIVIDUATION

In terms of group process, the factor of amalgamation with the group did not bear any specific relationship to the father-son concept. Instead, the participants reacted to the therapists as though they were both parent figures, just as children react to a big brother as a supplemental parent. In such an instance, the feeling of belonging or dependency became attached to the total group, even to the exclusion of both parent figures. Thus, the group itself became a symbolic mother, and the participants attained comfort through the mutual acceptance and understanding of each other.

Viewed from the aspect of ego development, the amalgamation phenomenon represents the recapture of the latency period when the oedipal situation is resolved and the dynamics of the family drama repeat themselves outside the home with one's peers. In effect the members of the group closed ranks in a phalanx against both therapists, just as children in this period establish channels of mutual communication with each other and try to keep out the prying eyes and ears of the adults.

The other aspect of ego growth which emerged from the group process was that of individuation. The members of the group attempted to attain a uniqueness, which differentiated them from other members of the group. Such individuality is, of course, derived from earlier exhibitionistic, attention-seeking or competitive drives but evolved in the group situation as a search for identity. In relation to the father-son leadership, the differences and uniqueness of each therapist helped to encourage each patient's acceptance of differences and individuality in himself. Thus, the ego design of each person may differ from the designs of other persons and thereby form an image which can make an impression on other people. This phenomenon normally develops in adolescence and is the precursor to finding and selecting a mate.

As his awareness of an individual identity is consolidated, a person is able to function in varied roles while maintaining a constant sense of self. The therapists' ability to function as leaders, to relate to each other and to patients, and to remain secure as individual personalities while performing similar tasks, served as a paradigm of integrated autonomy, setting the stage for such development by patients. Perceiving a possibility is a prerequisite to achieving an actuality.

SUMMARY

The conduct of psychoanalytic group psychotherapy with father and son serving as co-therapists, while patients generally remained in individual psychoanalysis with the senior therapist, has afforded the opportunity to observe unique transference phenomena including identification with the junior therapist as victim, displacement of aggression or libido from senior to junior therapist, and transfer of distance by denial of the relationship, as well as transference reactions based on the junior therapist as a sibling equivalent. As a living perceptual experience for members of the group, observation of the ongoing harmonious working relationship between the therapists has served as a model for introjection and extrapolation of interpersonal harmony and has enhanced the processes of amalgamation and individuation within the group.

GROUP DYNAMICS AND EXTERNAL LIFE CYCLES

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This paper uses data from short-term didactic training groups of student nurses to examine one hypothesis about group interaction. This hypothesis states that the intensity of emotional involvement of group members in the group itself is, in part, a function of the tie which the group's life cycle has to an external life cycle of each of the group members. In this instance the beginning and ending of the training groups is coincident with the beginning and ending of the individual member's psychiatric hospital affiliation. The coincidence of life cycles allows the normal group process to be accelerated since the problems of commitment, degree of involvement, and separation confront group members in the external situation and in the group at approximately the same times; experience in one setting reinforces experience in the other.

We shall also examine a second and related hypothesis: the intensity of involvement of group members in a group is related to the degree to which the usual defensive modes of the group members are threatened or made inappropriate by the members' external situation. We feel that the student nurses in these groups are thrown into a "crisis" situation when they move from a general hospital milieu to the "therapeutic milieu" of a psychiatric hospital; their usual modes of defense are made inappropriate and consequently they bring to the didactic training groups much affect which can be dealt with in the training groups.

We have no quantitative measures with which to test these hypotheses. Instead, we intend to use the hypothesis-testing model as a means of organizing our impressions with the goal of an explicit statement of hypotheses which are open for subsequent testing. If these hypotheses are supported by further tests, it is evident that taking account of the external experience of group members allows more efficient use of groups as training devices and also has implications for the understanding of group process.

PART I

Group Process in Short-Term Training Groups

These groups took place in a hospital to which the student nurse came for a three-month affiliation. The hospital is a small, intensive-treatment

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psychiatric hospital which is a teaching center for both medical and non-medical personnel; the nature of the hospital's therapeutic milieu and the conflicts which the hospital culture causes for the student nurse will be described more fully later.

Each training group consisted of from seven to fifteen members; groups met one hour per week for eleven weeks. Since the student affiliates came from five different nursing schools, members did not know each other prior to this affiliation. All students lived together in the hospital dormitory during their psychiatric affiliation.

The students ranged in age from nineteen to twenty-one and were in their junior or senior year of nursing. The schools from which the students came were three-year nursing schools which did not offer a college degree. The psychiatric affiliation was required by all schools, and no choice of a particular psychiatric hospital was allowed.

The leaders of the twelve groups used as a source of data for this paper were the two authors. They conceive their roles as participant observers who call the attention of the group to on-going behavior and encourage examination and clarification of group issues.

The purpose of the group was explained during the first meeting by the leader. Purpose was defined as "a group to learn about group process by participating in and observing what happens here in this group." Members were told that the group might talk about members' experiences in this hospital, about other issues in psychiatry, or about anything else that interested them. The confidential nature of the groups was clarified. The leader also set certain limits to the topics appropriate for discussion by specifying the differences between didactic groups and therapy groups (i.e., members were not expected to talk about everything that came to mind or about personal problems).

The data for this paper come from notes written by the group leaders after each meeting of the series of twelve groups; thus our data account for an approximate total of one hundred and thirty-two single group meetings. The limitations on this kind of recall data are obvious and are recognized by the authors.

We will describe the content of the group interaction and the process through which the groups developed in order to specify the nature of the group life cycle and to illustrate the intensity of the group experience and the directness with which many issues were dealt. The elements of group development and intensity are necessary to the clarification of our main hypotheses.

If we divide our series of group sessions into phases lasting three to four meetings, we can see most clearly the patterns of group development which seem to characterize all of the groups. In the beginning stage the

group members are concerned with getting to know each other and getting to know the leader. The major problem in this phase seems to be "who belongs how much to the group." In deciding how much each member will be committed to the group and to the leader, the group works toward building up a group culture which consists of recognized but usually unstated norms about behavior. It is in this stage that the "rules" for the group are settled, especially in regard to what can and cannot be discussed in the group, how involved members will be, and what kind of relationship the group will have to the leader. In the latter part of the first stage, the negative transference toward the leader becomes openly expressed and dealt with.

The following quotation from a first meeting of a group illustrates several of the major problems which are characteristic of the first stage of group development. The group is discussing the issue of privacy and fear of exposure in a group. They speak of this by displacement to their concern for the patients exposing themselves. A second theme is the wish to be told what to do, to "find a supervisor." This group concern is discussed by talking about their feelings of aimlessness and the anxiety it provokes on the ward.

Meeting 1. The leader introduced himself and explained the nature of the seminar. The first reaction to this was a long silence. Then Marie said that they discussed things in Miss R's class, too. She talked intellectually about how long it took sometimes to get acquainted with patients and learn how to handle one's feelings with them. Another long silence. Frances blurted out a question to the leader. "Why is it that the patients' personal problems are discussed in front of whole groups of people?" The leader asked what she meant. There were a few snickers about people around here always answering a question with a question. But Frances persisted. She had a patient who was quite upset about having to tell her problems to so many people. She said she knew just what the patient meant. She certainly wouldn't want to tell her problems in front of a whole group. It would be hard enough for her to talk to just one person.

Marcia said that she had come here prepared to meet crazy people but was surprised. It was hard for her to judge who the patients were. Most of the group smiled at this, but some looked frightened. Viola broke a long silence to say in a complaining voice that she didn't like it here. "No one tells you what to do. You just sit around and talk and play games. It is a waste of time." Long silence. Pat, who was sitting next to Viola, began to laugh nervously and whispered something inaudibly to Viola, who giggled. The leader asked if they would let the group in on it. Containing her laughter, Pat told the group that last week she and Viola were down at the market and a butcher hailed them. Before they realized what was happen-

ing, he had talked them into buying two pounds of bologna which neither of them wanted. The group roared with laughter.

After another long silence, Viola resumed her complaining, saying that nobody knew what was going on here. There are no rules. In their home hospital they avoid the supervisor. Here they don't even know who the supervisor is. After another long silence, the leader asked whether the group wasn't saying that this group seminar is a lot of bologna. The group burst into laughter.

In the later sections of the first stage the anger and frustration are expressed more directly toward the group leader rather than being displaced toward supervisors, the housemother, or instructors. In this part of Phase One the group is working directly with the leader's passive role and consequent apparent lack of control and the group's ambivalent feelings about freedom and the responsibility which it implies.

Meeting 4. Georgia walked in a minute late, sat down, and said in a defiant voice, "Do we have to come to these groups? Some of the girls didn't come to the last group and I don't see why we have to come." There was a gasp from the rest of the group and then an embarrassed silence. Sandra glanced around the table and then said, "Well, if we're going to learn anything about groups, we have to come. We get out of it what we put into it. If we sit here like a bunch of blobs, we'll get nothing." Sandra finally looked directly at the leader and said, "I wish you would tell us things but you won't. At least, you haven't so far." Georgia commented, "It's just like psychotherapy. You just nod and don't talk. Why do we have to come if we don't want psychotherapy?"

They went on to talk about how the group is like the hospital: "There's so much freedom. We're not used to it. On other affiliations we're put in a narrow path and can't get out of it. And here if we don't do something no one knows or cares. Except us."

"And then we ask someone what to do and they just turn the question back to us. It's like supervision where you ask your instructor something and she says, 'What do you think?' She just sits there and stares at you." Janet said, "I feel like I'm being psychoanalyzed; I don't like the idea of having someone look at me and think what kind of person I am." The leader asked if some of this might have to do with this group. Georgia asked, "Are you doing research on this group?" Others felt this was probably true. Eileen wondered whether the leader had been dragged into leading the group. She finally asked, "Why are you interested in us? Why don't you tell us what to talk about?"

This first phase of the groups seems to continue through the fourth or fifth week of the affiliation, at which time problems of commitment and negative feelings toward the leader seem to have been partially handled to

the point that positive feelings toward the leader and group members can come up more clearly. The group deals, directly and indirectly, with feelings about how close members can get to the leader and to each other, what the implications of these warm feelings are and how they can be appropriately expressed. During the latter part of this second phase the group begins to move, slowly, toward the problems of separation.

In the passage below, selected from a different group, we note a continuation of the theme of privacy and fear of exposure from the first phase. But there is a difference. The group is now discussing the topic of sexuality in an animated way. They responded to such topics during Phase One by saying, "There's too much Freud in the hospital," or, "All anyone here talks about is sex." In contrast, in this meeting they seem to be saying that sexuality is an interesting topic to talk about; it is on our minds, too, just as it is on the patients' minds, but it's a personal matter which we as a group have tacitly decided not to discuss. We can note how the group has begun to generalize its experience to understand behavior in other groups. There is less plea for guidance evident, also.

Meeting 7. The group is talking about one of the patients, D. Linda says that she is in her twenties. She's a very slow-moving girl. Judy interrupts and adds rather unbelievably that D. had been going with the same man for ten years and couldn't make up her mind whether to get married. She tells how shocked she was when she discovered that D. had been having sexual relations with her fiancé. This led to a general discussion of how this girl talked about such intimate things to them before they really knew her. Doris says that she knows one of her friends was having relations but it didn't change her opinion of her because she knew her well. The leader points out that the group seems to be saying there are certain times it's appropriate to talk about personal matters but you have to know each other first. He asks if that sounds familiar. Iris says it sounds like the talk in the first few meetings when "we didn't know each other and thought we were supposed to talk about personal problems." The group agrees that it's hard to say something in the group unless you know it will be accepted.

Greta interrupted a silence to say rather sadly that M., their instructor, was leaving. They hate to see M. go. She called them by first names and made them feel comfortable. S., their new instructor, came to her first class and was greeted with a cold, uneasy silence. Greta says that it was just like some of the silences here in the group when they were angry. Elizabeth says that she felt sorry for the instructor but couldn't speak up because she didn't want M. to go. Greta says guiltily that the new instructor excused herself from the class, saying she was feeling sick. The leader comments that the group seems to have discovered that groups can say things with silence as well as with words.

The third phase of the group process is centered around the problem

of separation. In this phase, a definite hypomanic mood usually precedes a slowed down, "sticky," depressive mood as the group works over its feelings of separation. The group is able to see for itself the ways in which leaving involves both warm feelings and anger; the mechanisms for dealing with separation are also important aspects of the final meetings: denial, "looking forward," and displacement. At this stage the group also works to put its experiences in some perspective and tends to compare behavior in the seminar with experience in other groups.

In the quotation which is given here as an example of a final-phase meeting, the intensity of affect is most apparent. The group moves rapidly from a hypomanic excitement to feelings of depression. Members work together examining their own behavior, comparing the resistance of the group to the resistance of their patients. They seem to be able to use this type of comparison without the feeling that their sanity is threatened as in the first stage. A positive transference toward the leader is evident. Some members of the group confirm the impression that individual members as well as the group as a whole have grown.

Meeting 11. The whole group came in giggling, laughing, and singing. Carol sat down, started teasing the others, and, at the same time, took everything out of her purse and spread it on the table. The rest of the group was equally excited; everyone talked at once and there was a great deal of giggling.

Alice commented that the group certainly was different from last week when Anna had talked about how terrible it was to go to visit the state hospital. This had upset all of them. While Alice talked, Carol and another member continued to giggle among themselves so that others couldn't hear. Finally, Joan said in a very pointed way, "Why don't you leave if you can't stop laughing?" In the midst of the hilarity, Carol got up, walked out of the room, explaining that she was leaving because she couldn't stop hiccupping. There was a long silence. Group members looked at each other. The leader asked, "What has been happening in the group today?" Alice said that there was a lot of laughter because the group didn't want to talk about what was important, the fact that they were leaving next week. Just at these words, Alice's pen, which she had been gripping in her hand, snapped in two. Carol commented, "I didn't know you felt so strongly about it." Alice looked up with a surprised expression and said she guessed she did feel strongly and hadn't realized it.

Then a long period of silence. Alice said she didn't want to talk about leaving or even think about it till the time came. Jean reported that she had told her patient that she was leaving and the patient said she didn't care. But the next day the patient told Jean that she was counting the days and didn't want to let herself feel sad. Jean said it is going to be difficult for her

to say good-bye. Ann, who had been listening quietly, said that, "The patients say that when we go away, it's as if we are dying."

This starts a lively discussion among the whole group about their next affiliations and the possibilities of seeing each other again. Anne said that they could see each other again, but it was different with the patients because they were cut off entirely and "it is just as if we had died." Jean noticed that nobody had said anything about seeing the leader again. Long silence. Carol pointed out that they seemed to be finding it difficult to talk about the group coming to an end. Anne said, "I feel as if I were being left instead of leaving. I don't like to think of the fact that my patient will have another nurse. Will the leader have another group?" Dot asked, "Why do you ask?" Alice answered for her: "It makes her angry to think that we will be replaced." Stella had been participating by listening. She had beginning tears in her eyes though her voice was unwavering as she told the group that she had the feeling all week that she had left something on the ward by mistake. Another girl said she had the same feeling. "It is as if we are leaving part of ourselves behind. But we feel we've learned something, too." The leader pointed out some of the differences in the way they felt as a group now compared to the beginning. He also pointed out that some of their attitudes seemed to have changed. Stella smiled and said that they were discussing that last night in the dorm. She felt she is so different. It's as if she can feel more herself now. There was a depressed silence.

In describing the development of these short-term groups, we have noted what seems to us to be the sequence of major group problems: first, the groups work on problems of commitment and the negative transference toward the leader; next, the positive feelings toward the leader and the group members are central; finally, the group deals with separation, the loss of the leader and the loss of the group as a whole. It is clear that no phase is sharply defined; all three of the problems are evident in each of the three stages. In these groups, as Bennis and Shepard (1956) have pointed out, "Each group meeting is to some extent a recapitulation of its past and a forecast of its future."

The stages which we have described are in some sense comparable to those which Bennis and Shepard describe for longer-term training groups. These authors suggest that the two major problems on which groups must work are the problems of dependence (power relationships), and interdependence (personal, or affiliative, relationships) in that order. Schutz (1959) further refines the phase sequence to separate out a first phase which deals with the problems of inclusion or commitment; his later two stages are, in general, similar to those of Bennis and Shepard.

In a general sense the didactic groups which we have described also seem to follow a similar sequence. There is one major difference, however, which we feel is worth noting. In these groups the dependence and inter-

dependence problems seem to be most directly handled by the group in terms of the group's relationship toward the leader; much less attention is paid to the problem of dependence and warmth toward other group members. Schutz has suggested that the problems of inclusion, control, and affection must be worked out first with the leader and that only then is it possible that these feelings can be handled toward other group members and the group as a whole.

The stress upon the group's relationship to the leader may be a function of two characteristics of the group. First, the fact that the groups are short-term (eleven meetings) may necessarily result in a certain amount of "telescoping" of group process. The group makes "a decision" to concern itself largely with feelings toward the leader; the same relationships toward group members are dealt with only secondarily. Why the group "decides" to concern itself to a greater extent with the leader may also be a function of the setting in which the group is meeting. As we will describe in a subsequent section, this hospital affiliation is one in which the student's usual relationships toward authority figures are found to be inappropriate; this brings into major emphasis in the group the feelings about authority which have been aroused in the members' external experience. It is probable that the short-term nature of the group and the arousal of authority problems externally each contributes to the group's major concern with its relationship toward the leader.

Summary

In Part I, we have attempted, in describing the content of the group interaction and the sequence of group development, to demonstrate two points essential to the two hypotheses outlined in the introduction. First, a meaningful and intense experience can occur in didactic training groups which have a short life cycle (eleven meetings). The directness with which many problems were dealt by the groups and the amount of involvement seem to us to be evident in the portions of meetings we have included here as well as in the data from which these were drawn. Secondly, the phases through which the groups move are "complete" in the sense that we are able to distinguish the major phases which group theorists have derived from longer-term groups.

The complete movement through the major phases and the intensity of the group members' involvement in these short-term groups seem to us to be unusual. Because the group cycle is coincident with a life cycle outside of the group, we feel that the problems and feelings brought up in one area of experience intensify the problems and feelings in the other. This circular reinforcement of conflicts allows the didactic groups to work (with "borrowed" effect) more directly and more quickly on relevant group problems.

Synchronization with some other time unit which is meaningful in the current life of the group members may be more important than the number of meetings or other factors.

PART II

In this section we intend to examine a second, and interrelated, hypothesis. In brief, it is that the intensity of involvement of group members in a training group is related to the degree to which the usual defensive modes of the members are threatened or made inappropriate by the members' external situation. The student nurses in these groups are thrown into a "crisis" situation when they move from a general hospital milieu to the "therapeutic milieu" of a psychiatric hospital; their usual means of coping with anxiety become useless, and, consequently, they bring to the didactic training groups much affect which can be dealt with in the group context.

The External Situation

The social structure of the "therapeutic milieu" type of psychiatric hospital and the accompanying role expectations of nurses is markedly different from the structure and roles which these student nurses have learned in the general hospitals from which they come. Each of these social systems develops and rewards a particular set of defensive patterns for dealing with the unacceptable impulses and anxiety related to nursing tasks. Since the rewarded modes of defense differ so radically between the general and the psychiatric hospital, a move from one system to another robs the student nurse of her usual means of dealing with impulses and anxiety in her job; she is thrown into crisis, and in this situation is readily accessible to group involvement.

Menzies (1960) has provided an excellent description of the role patterns and institutional defenses learned by students in the nursing service of a general teaching hospital. Though her study is of an English hospital, it seems to describe admirably the general hospital nursing services from which these student nurses come. As we shall see, these general hospital role patterns are almost the exact opposites of the role expectations and defensive modes which are rewarded in one type of psychiatric hospital, a hospital committed to the therapeutic milieu approach to treatment. (Greenblatt [1955] has described more fully this hospital's treatment approach.)

The nurse in a general hospital is constantly presented with anxiety-provoking stimuli. Menzies (1960) writes, "Nurses are confronted with the threat and the reality of suffering and death as few people are. Their work involves carrying out tasks which, by ordinary standards, are distasteful,

disgusting, and frightening. Intimate physical contact with patients arouses strong libidinal and erotic wishes and impulses that may be difficult to control. The work situation arouses very strong and mixed feelings in the nurse: pity, compassion, and love; guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy of the care given the patient. The objective situation confronting the nurse bears a striking resemblance to the fantasy situations that exist in every individual in the deepest and most primitive levels of the mind. The intensity and complexity of the nurse's anxieties are to be attributed primarily to the peculiar capacity of the objective features of her work situation to stimulate afresh these early situations and their accompanying emotions" (p. 98).

"The needs of the members of the organization to use it in the struggle against anxiety leads to the development of socially structured defense mechanisms, which appear as elements in the structure, culture, and mode of functioning of the organization. . . . The socially structured defense mechanisms then tend to become an aspect of external reality with which old and new members of the institution must come to terms" (p. 101).

Menzies then proceeds to delineate several defensive modes which are developed within the system to deal with anxiety aroused by the constant confrontation with unacceptable impulses. Having learned the role and defensive modes in a general hospital such as Menzies describes, our student nurses are then thrust into a hospital structure in which the behavior expected of them is much different and in which the defensive patterns which they have learned are not rewarded.

In the hospital from which the students come, they have learned, as Menzies points out, to split up their relationships with patients. They perform particular tasks for many patients, which dilutes the opportunity to relate to patients as individuals. In contrast, the nursing role in the psychiatric hospital demands that the student be in prolonged, intimate contact with a few patients. Students spend many hours per week talking with and about one patient selected for a case study. They perform most of the nursing tasks for this patient and become a highly significant object in the patient's life. Thrust into such intimate patient contact for the first time in her career, the young student is robbed of the protection afforded by the splitting of the nurse-patient relationship. She is forced back upon her own individual defenses.

In the general hospital setting the student nurse is taught implicitly that any nurse should feel the same about any patient. This mechanism of depersonalization demands that patients be "cases" and that diagnostic categories and the role of the patient define the nurse's interaction rather than any individual personal characteristics. At all times she is to be professional. The nursing student is barely introduced to the psychiatric hos-

pital before she is literally stripped of this protection. It is customary for members of the staff to wear street clothes, which is part of a conscious effort to break down the barrier between patient and nurse. Patients and staff often call her by her first name. She is allowed to choose her patients and does so on the basis of her own personal inclinations toward people. At first the change is anxiety-provoking and one hears statements in the group like, "I don't like it here; I prefer a professional atmosphere; I like a uniform; it makes it easier to tell who people are."

The loss of the depersonalization mechanism leads to humorous as well as frightening situations for the student nurse. One student reported, "B., the attendant, came up to me and asked me to play chess. We played for a while and then he asked me, 'What are you in for?' I laughed and told him I was a nurse. He didn't believe me."

Another student had a similar experience with a ministerial student. "We were talking and he began to ask me some questions about my family. He said that he could understand how I felt being a patient because he had been in treatment himself. He told me later that he wanted to select me for his case study."

Though some take this confusion light-heartedly, others are very upset. With the breakdown of distinction between nurse and patient, they are flooded with anxious questions about their own sanity: "Some of the patients look better than we do." Not only is this fear activated by the removal of usual professional defenses, but the inclusion in the patient population of numerous adolescents, college students, and professionals provides them with patients with whom they easily identify. "Miss M., a graduate from our hospital, was admitted today. There are several doctors on our ward, too. One of them would have been chief resident if he hadn't gotten sick. I guess doctors and nurses get sick, too. They seem like exaggerations of ourselves."

With the removal of the role pattern which allows splitting of the nurse-patient relationship and which rewards denial of the significance of the individual, the student nurses in the psychiatric hospital are quickly exposed to the full intensity of their feelings toward their patients. They can no longer utilize the mechanism of detachment. This is often frightening.

One student reported in the group, "Miss K., a young adolescent girl on the ward, came up to me and started to talk in a friendly way. She seemed different than anyone I ever knew. She started to tell me about all of her affairs. It made me feel funny. She talked about some homosexual experiences, too. When she told me that she liked me, I didn't know what to say. I told her that I was the nurse and she was the patient." Another student reported having a young male patient run up to her and throw his arms

around her. In terror, she shoved him away, he fell to the ground, and then he laughed. "I felt awful," she said.

Detachment and denial of feeling is not only not rewarded in the psychiatric setting but it is hardly allowed. In the beginning, students may withdraw from patient contact but their supervisors constantly push them, encouraging involvement. "Every time I sit down by myself the head nurse tells me to go over to a patient and talk with him. They won't leave you alone." In addition to this ward experience the students have individual supervisory sessions to discuss their patients. The focus is on their interaction with the patient. This is often interpreted by students as being "psychoanalyzed." "The instructors keep asking us how we feel about everything. They ask why this and why that. You can't keep asking 'why' about everything. You'll go crazy."

Ritual task performance is still another defense pattern which Menzies finds is developed in a general hospital setting. This, too, is not available as a defense in the psychiatric hospital. There is no emphasis on the procedure book, and it is not a legitimate means for avoiding contact with or individual responsibility for patients. As in the other instances in which usual defenses are not rewarded, the student nurses respond to this with irritation and anger. In the group they say, "This place is sloppy. There is nothing to do here but talk. It's like a vacation. I can't wait to get back to my home hospital and do a real honest day's work."

In addition to defenses against close involvement with patients, Menzies also lists a number of defenses employed by nurses in the general hospital to avoid the anxiety associated with the responsibility for patients' care. Checks and balances which avoid any individual responsibility go along with the procedure of the general hospital. These are not found in the therapeutic milieu, where the matter of responsibility is very complex. The students at first think of their job as responsibility to do something for the patient and to do it correctly. But the psychiatric hospital defines the patient role differently, and this of necessity changes the nursing role. The patient is expected to be responsible for himself to the degree to which he is able, and when the student nurses first discover this, it seems to leave them without a job, without responsibility. But then they hear that they are expected to be part of a therapeutic team. They are expected to involve themselves in a unique way with the patients. She spends more hours per day with the patient than any other member of the team, and she is given the general task of fostering healthy behavior. In part, this involves participation in the milieu activities. There are few other orders given. Implicit in her task is the responsibility to be her most mature self. Instead of being without a job, she is given a task which must seem most difficult to late adolescents: you fulfill your responsibility to your patient by being re-

sponsible to your mature self. This involves constant examination of one's own behavior. The students complain, "The instructor just sits there and waits. When I say something about a patient, she asks why I brought it up. When I don't talk, she asks why. She's a frustrated psychiatrist. It could drive you 'bananas.'" Later, they learn to do this themselves to increase their own effectiveness.

In the general hospital, Menzies describes the ways in which responsibility is shifted upward and low-level tasks which are often beneath their personal ability are left to student nurses. In the psychiatric hospital's therapeutic milieu the student performs tasks to the limit of her personal ability. This alone defines the manner in which she does her job. Symbolic of this is the often-times irritating habit of staff members more senior in the hierarchy of refusing to answer questions. Questions get answered with questions. Some students are infuriated by this in the beginning. "Why don't they answer questions? We don't want to know 'why' about everything. There are some things that we just can't answer by ourselves. They are supposed to know more." The last statement touches on the fact that is the most anxiety-provoking, for the students begin to learn that their seniors keep asking "why" because they don't really know the answers, and that, what is more, there are no answers. Instead of following clearly prescribed orders the students are left with the awesome responsibility of deciding for and being themselves.

The final major control over anxiety which develops in the nurse's role in a general hospital is the strenuous avoidance of changes in the social structure and mode of operation. In contrast, the hospital in which the students affiliate for their psychiatric training is committed to individual and institutional change. The staff is always experimenting with new ways of working, and trainees are looked upon as a constant source of new ideas which may be worthy of translation into action.

Being asked for ideas about handling ward problems and activities is a new experience for the student nurse; she is hesitant and wary about making suggestions, especially when these are requested by staff nurses and doctors who are more senior in the hierarchy. This new experience in instituting change is anxiety-provoking. Methods and rules are constantly being changed, and these changes result in frequent alterations in what the student nurse does in her job. The relatively short length of stay for the student does not allow her to learn what the "boundaries" of change are, and therefore she feels herself to be in a situation which is apparently amorphous and unpredictable.

The three-month period is, however, long enough for the student nurse to sense the attitude toward change in the therapeutic milieu as compared to the general hospital. "Why don't we start a group like this in the general

hospital? (The group seems enthusiastic.) The old grads wouldn't go along with it. (A sigh of resignation.) I guess when we become grads, we'll become set in our ways, too."

It is clear that the student nurse who comes from a general hospital setting to a therapeutic milieu type of hospital for a psychiatric affiliation is deprived of every defense against anxiety which she has learned and which is rewarded by the general hospital system. The student nurse's discovery that her learned defense patterns are inappropriate leads us to suggest that the individual student nurse is thrown into a "crisis" situation. She is faced with a life situation which results in problems which cannot be solved by ordinary problem-solving methods. Caplan (1960) points out that in such a crisis situation minimal intervention at the time of crisis can have far-reaching effects out of proportion to the small expenditure of time and energy. In the group-dynamics seminars the students are reached at a point of crisis when they are highly accessible to re-examining their behavior; we feel that this sudden instability of learned defenses allows for intense involvement in the training groups.

CONCLUSION

We have previously stressed that the coincidence between life cycles of the didactic training group and the members' external experience allows circular reinforcement from one to the other and thus results in a more intensive and speedier development of the group process.

We have also pointed out that more intense involvement in a didactic group may occur when the group members in their experience outside the group are confronted with a crisis situation in which their usual modes of defense are no longer rewarded. We have compared Menzies's description of the usual defenses developed by nurses in a general hospital with the defenses rewarded in a "therapeutic milieu" type of psychiatric hospital. The student nurse who comes into the psychiatric hospital is confronted with the inappropriateness of learned behavior. This results in a crisis situation in which the student nurse group is more accessible to the re-examination of its behavior.

These hypotheses have implications both for theory and for the planning of training groups. If crises external to the group affect group behavior, then the fact of and content of a crisis must be taken into account in theoretical constructions. If it is true that the crises in a life cycle of experience open more interpersonal relationships to re-examination in a training group, then this can be taken into account in planning other training groups in other settings.

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PROBLEMS ENCOUNTERED IN ESTABLISHING AN "INSTITUTION-TO-COMMUNITY" GROUP THERAPY PROGRAM FOR DELINQUENTS¹

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This paper describes some of the efforts made by the authors during the past five and a half years to find workable approaches to the problems with which a small percentage of the adolescent population confronts the community. The boys and girls with whom we have dealt were, when the study began, 14 to 16 years of age. They are the unfortunate youngsters whose exploits are frequently described in the daily newspapers. They are the boys who clutch the steering wheel of a stolen automobile, and not infrequently bring it to an abrupt stop against some obstacle. They are the boys who, in the dark of the night, remove a pane of glass from the back door of a store, take money which they squander on sweets and shows or remove merchandise which they do not try to sell but abandon in a dump, under a bridge, or in some bushes. They are the boys who stand before the judge, looking bland and sad, giving monosyllabic answers and almost invariably stating that they know no motive for their actions. Occasionally, it is the boy caught trying to find release for his tensions by enticing or forcing smaller children to indulge in sexual acts. Rarely, it is the boy who has committed a serious crime (in the past five and a half years, three adolescents in our city have been detained because they killed somebody). The girls in our groups were apprehended, in some instances, because they were found on the street late at night or because they had run away from home or because they had persistently refused to attend school. Others were willing to follow adult men in search of pleasure. These are the youngsters who, after a sleepless night in the detention room, face the Family Court judge, looking haggard, dishevelled, their clothes rumpled and dirty, with despair, bitterness, anger, and unhappiness in their eyes. At times, an ill-fitting skirt fails to conceal the evidence of an early pregnancy.

These boys and girls our society calls "juvenile delinquents." Frequently the community wants them segregated, and frequently, indeed, it is a necessity. To that end they are remanded to institutions called training schools or industrial schools to be rehabilitated. In Rhode Island, a state-

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operated outpatient clinic, known as Mental Hygiene Services, furnishes psychiatric and psychological services to the training schools. The three co-authors of this paper, two social workers and a psychiatrist, are on the staff of this clinic.

INITIATION OF GROUP THERAPY IN TRAINING SCHOOLS

A perusal of the literature suggested that group therapy was the treatment approach best suited for a significant percentage of the population we were dealing with. Consequently, in the fall of 1956, group therapy was introduced at the Rhode Island Training School for Boys and shortly thereafter at the Rhode Island Training School for Girls by Miss Benson and Dr. Sadovnikoff. A number of groups were started, very little consideration being given to the selection of candidates according to age, diagnosis, or personality make-up. Changes in this approach had to be introduced time and again. Also, we soon realized that it was unwise to maintain Miss Benson in the role of silent recorder-observer, and she became a co-therapist. A paramount problem was that the initial reaction on the part of the school personnel was distrust and, at times, more or less overt criticism. The strongest objection was that the therapists were condoning and even encouraging disrespectful behavior on the part of the boys and girls. This apprehension on the part of the personnel that their authority was being challenged was an important issue which had to be considered carefully. It is clear that identification of the therapist with his patient when the latter is living in a setting where expression of feelings is restricted may readily lead to conflicts with other members of the staff. Thus, it is imperative for the therapist to work through his problems in this area so that his patient will know unequivocally that there is no uncertainty as to whether he must maintain a respectful attitude toward all the adults dealing with him (even though there may be differences in ideology between some staff members who favor a repressive approach and the therapist who wishes to encourage limited seeking of insight in his group and, therefore, tolerates or, on occasion, encourages some testing and challenging by his patients).

Another problem area that quickly presented itself was our failure initially to make a sharp separation between treatment and administrative procedures. In our first group the members demanded that the therapists show their love and interest by promoting their discharge. The members came to the point of refusing to discuss any issue other than that of their release from the training school. Mounting activity, disruption, and finally aggressive acts resulted in complete disorganization and forced us to disband this particular group three months after its inception.

A "post mortem" analysis of the sessions demonstrated clearly that the

anxiety generated in the members by the therapists' efforts which tended to promote closeness had become unbearable; to escape from it, the group chose the issue of their release as the battlefield. In subsequent groups, we therefore made it entirely clear that the judge—and nobody else—can remand a youngster to the training school, and that the judge alone can order his release.

INSTITUTION-TO-COMMUNITY GROUP THERAPY PROGRAM

After some two years we came to the conclusion that the results obtained during the stay of the group members at the institutions were frequently undone subsequent to their discharge; i.e., after their return to the same living conditions under which they had developed symptoms. A logical step to prevent such an outcome, we reasoned, was to continue meeting with the same group outside of the institution after their discharge. The behavior of some of the group members themselves suggested that such a plan might be useful; a small percentage of the youngsters sought us out in the community on their own after their discharge from the training school. We did not find similar projects in the literature and, therefore, decided to apply to the National Institute of Mental Health for a grant to support a project which received the name of "Institution-to-Community Group Therapy Continuum."

A sum of \$25,000 a year for three years was granted to hire additional personnel (full-time social worker, clerk stenographer), to purchase equipment (tape recorder, movie camera and projector, Polaroid camera, furniture), food and cigarettes, and to rent space in the community for the meetings. In addition, money was earmarked to pay consultants: a sociologist, a psychologist, and a psychiatrist. Miss Benson continued in the capacity of co-therapist, while Mrs. Packard was assigned to the task of making contact with the parents of the children and of being a liaison between them, the children, and ourselves.

Two separate groups, one at the Boys' School and one at the Girls' School, each consisting of eight members, were formed. While there were many boys to choose from, the population of the Girls' School at the time was very low, making it necessary to include girls who, had the number of candidates been larger, would not have been accepted, either for reasons of low intelligence or inadequate ego strength. Shortly after a group of girls (age 14-15) was formed, two of the girls ran away from the institution. Since we wanted to maintain a closed group, we did not replace these girls in the group, although in our opinion it is difficult to apply the techniques of group therapy if the group is too small. Tension and uncommunicativeness increase as membership decreases, for this type of patient finds

strength in groups and feels more and more exposed and threatened as the group diminishes in size. In our experience the number should not drop below five.

In order to obtain a pool from which to make selections for the boys' group, we turned to the personnel of the training school (such as members of the social service staff and counselors) with the request that they list the boys they considered likely prospects. Each boy's record was then reviewed, and a number of candidates were eliminated. Certain criteria had to be met. To avoid post-discharge transportation problems, we restricted our choice to residents of an area roughly 10 miles in radius from the site of our outpatient facility. We did not select anyone of below-average intelligence. In addition, we investigated the personality make-up in the hope of being able to achieve a balanced group. We wanted to avoid finding ourselves with either a group of withdrawn, uncommunicative members, or with a group of overactive, disruptive children. We were guided by Slavson's concepts as outlined in his *Introduction to Group Therapy* (1943) and in the principles evolved in his "activity group therapy." The goal was to have active members ("instigators") who would tend to influence the group in the direction of regressive acting out within the session, coupled with passive members ("neutralizers") whose inclination would be to stem the tide. Borderline psychotics and severe impulse disorders were excluded, leaving the diagnostic categories of character disorder and neurosis to be drawn on. What the diagnosis is does not seem to matter very much if the main criterion for selection is a concern for cohesiveness and equilibrium. It was our consultant's impression that we could readily mix the two in one group as long as active members were balanced by passive ones.

Concerning the age of the members, we decided on youngsters 15 to 16 years old because, at this age, they are getting away from the earlier turmoil of adolescence. Furthermore, there is a certain amount of detachment from their parents which facilitates the working through of dependency needs, and the parents themselves are more receptive to the suggestion of letting their children go because they can see that they are approaching adulthood. We had no particular concern about the physical size of the prospective group members as long as their psychological state of development was roughly the same, but it was deemed wise to avoid having members who would be too unprepossessing or handicapped, and, thus, natural candidates for scapegoating.

In deciding on the physical environment of the meetings, we felt that the group therapy room should be neither too large nor too small. If it is too small, anxiety over bodily closeness may mount; if it is too large, it may

emphasize a feeling of distance and offer an unwelcome opportunity for dispersion. Ours measures approximately 20 x 30 feet. It is equipped with simple, but attractive modern furniture. The room is painted with warm colors; neutral, decorations hang on the wall. Cigarettes and food are placed on the table for everyone to share.

At the initial session of each group, the therapist stated that the meetings were intended to give the youngsters an opportunity to take an inventory of themselves and to decide whether or not they wished to make changes. It was pointed out that, after all, they were not little children who could not take care of themselves and were out of control, but that rather, by virtue of circumstances which remained to be appraised and discussed, they had been indulging in a kind of behavior which offered only short-lived gratification and much discomfort and distress. It was stated unequivocally that no violent physical contact would be tolerated between them or against the therapists and that, instead, they would be encouraged to talk about their inner experiences.

In such groups as these, it is up to the therapist to protect the members from their own aggression in order to insure a feeling of security. In time the therapist becomes a model for identification, and the youngsters come to terms with their conflicting wishes. On the one hand, they tend to retain their orientation (hatred of authority regardless of common sense considerations, contempt for the adult, unwillingness to consider the future, yielding to impulse, and so on), but, on the other hand, they realize that the adult therapist has their interest at heart and that to become like him is not so much out of the question as they originally assumed it would be. In the course of the years, we have seen a number of youngsters adopt our tastes in certain areas, for instance, clothing, music, or automobiles, even though no deliberate effort in this respect on our part was made.

In time, it becomes evident that a certain amount of introspection goes on which has been stimulated chiefly by an increased awareness of the self. Rarely do we use interpretations; most of the time we offer clarification and, on occasion, a confrontation is made. In our experience the therapist does not have to be as active in such groups as he is with groups of neurotics and even psychotics in institutions. It is more important to create a certain atmosphere. Once this is done, the youngsters will utilize the forces available in the group to their advantage with a minimum of intervention on the part of the therapist.

To create such an atmosphere for groups of this kind, specific points should be kept in mind. (1) Concerning the problem of their relationship with authority, a "neutral" attitude on the part of the therapist is imperative. This attitude is different, however, from that of the analyst behind the couch; the latter will allow anxiety to mount, but we avoided this,

especially in the early stages. While the patient in the analytic situation is also confronted with a person who represents authority, it does not have the specific connotation encountered in work with delinquents. For them authority is both punishing and depriving, and this negative aspect greatly overshadows the potentially helpful side. The therapist's "neutral" attitude is, therefore, designed to convey the idea that he is not going to punish or retaliate. It has to be "neutral" because a display of overt friendliness at first will generate suspicion and will be seen as an attempt to deceive.

(2) A second important issue is that of deprivation in the past. Most of the youngsters we work with have suffered from a lack of adequate supplies, both emotional and material, in varying degrees. In this context the therapist makes it clear that he will be a giving person. The members must become convinced that they will have his undivided attention and interest during the allotted time. In addition, food is supplied as a token of the willingness to give.

In our experience, group therapy with delinquents can be successful only if effort is expended to provide for an adequate milieu. This means preliminary work with institutional personnel and others who come into professional contact with the group members. Since it seems to be the rule that the staff of a training school is at first apprehensive over the intrusion of social workers, psychologists, and psychiatrists, it is desirable to spend a considerable amount of time becoming acquainted with the personnel and allowing them to realize that cooperation with an organization such as, for instance, Mental Hygiene Services will be of benefit to the institution which they administer. In our case, due to the aforementioned circumstances, there was no planned preliminary contact as we had worked in collaboration with the personnel for three years preceding the project, but regular meetings held at monthly intervals with the cottage masters and other members of the staff of both schools were begun as the groups started. Meeting with the staff of the Boys' School at the slow rate of once a month and considering the fact that there was some turnover among the personnel, it took some two and a half years to establish what we believe to be a working relationship. As stated above, there are inevitably elements of mistrust, competition, and resentment; the most common themes were, in order of their importance: (a) the issue of discipline (with frequent references to the times when the institution was run differently, i.e., more rigidly, as compared to the present more flexible line. It was often questioned how the cottage masters could enforce discipline and prevent or quell disturbances if they were not supported by firm directives from the head office?); (b) a tendency to challenge and debase (the cottage master spends eight hours a day with the boys while the Mental Hygiene Service members are with them for only a fraction of that time); (c) attacking the

administration on all levels; (d) how can they handle the difficult boys?; (e) how to "reach" boys. In the Girls' School with its smaller staff and smaller population the emphasis remained almost exclusively on the handling of disturbances. The problem of the relationship of the cottage mothers with the administration and with Mental Hygiene Services remained in the background.

Since our plan called for continuation of treatment after discharge, it was decided to meet regularly with the probation counselors assigned to the group members while the members were still in the institution. At the regular monthly meetings with the probation counselors the first sessions were devoted to acquainting them with the aim and mechanics of our project, but as time went on, these meetings were used as a means of learning to know each other, as well as an opportunity to discuss group dynamics. They were most valuable for the recognition and prevention of maneuvers designed to play one adult against another. While the meetings cannot be called group psychotherapy, of course, phenomena observable in bona fide therapeutic groups were encountered. The monthly sessions were seen as stimulating experiences where impressions concerning the children could be exchanged and something could be learned under the guidance of the therapists. It is our impression that the existence of such a group made it easier for the counselors to carry on their rather discouraging task.

The same is true of observations made in the setting of the third major part of the project: the work with court personnel. Regular meetings with the judges, the intake workers, members of the police force, representatives of social welfare and public assistance agencies, educators and ministers served the purpose of unifying people from different professions in the task of rehabilitating not only the members of our groups but other adolescents as well. Consistent work with the agencies involved in handling the delinquent and his family is of prime importance. The findings of our study in this respect suggest that several months may be well spent in becoming acquainted with key personnel, for it is important to give them an opportunity to become comfortable with those who are going to work with them in rehabilitating delinquents.

Reactions to the psychiatric team varied from unconditional acceptance—which can be troublesome as the team was at first burdened with decisions which were not theirs to make—to considerable hostility and conscious or unconscious maneuvers to disrupt the work. This suggested to us, particularly in relation to the probation counselors, that it is probably advisable to take into consideration the attitude of the particular counselor assigned to a boy or girl when making the selection of group members. If treatment is to be successful, it is essential that the probation counselor adhere to his role as the representative of the court authority and as the

man who makes realistic decisions. In fact, all adults—judges, probation counselors, cottage masters, and others—who have entered the life of the delinquent must remain within the confines of clearly defined roles. This is important because of the lack of stability so frequently observed in the background of many delinquents. In the case of one boy we promoted a meeting of all the agencies involved with him and his family. Some twelve people representing eight different agencies gathered around the table and expressed their views, which were often divergent. It became evident that this state of affairs was contributing to the confusion which this boy had expressed during sessions with the group. It also looked as if it played some part in the emergence of regressive trends leading to minor antisocial acts.

In the course of our sessions with the court, which, as mentioned, were attended by members of other interested agencies, we had to explain repeatedly the purpose and the *modus operandi* of the project. In addition, much time had to be expended answering questions which indicated that some of the participants had grave doubts about the usefulness or the rationale of our undertaking. It was only after ten two-hour meetings that a positive orientation could be observed. Initial hostility and unwillingness to become involved were gradually replaced by a wish to cooperate and by evidence of identification with the members of the therapy team on the part of a number of participants.

GROUP PSYCHOTHERAPY WITH DELINQUENTS

So far as the process of group psychotherapy with delinquents and its dynamics are concerned, the following observations, which find confirmation in a number of published papers, are offered. Briefly, we have noted a certain sequence of events in every new group: the initial phase, lasting only a few sessions, has been one of tension, activity (the younger the members the more activity), and ambivalence in relating to the therapist. Inevitably there were questions about why the members had been chosen and the conclusion was invariably reached that, if they were to meet with a psychiatrist, they must be "nuts," even though they had been given the alternative not to join. After the initial turmoil there supervenes a period of quiet behavior; frequently the members talked about helpless animals and about cruelty inflicted upon animals. By the end of the first year a certain amount of basic trust has been established. Worded differently, the view of and expectations about the therapist are not as rigidly held as they were before treatment. The fear of being exploited and of losing the object once more, should they allow themselves to establish a relationship, is somewhat lessened. One may observe a shift, noticeable only over a long period of time and not readily recognizable in the verbal content, from impulsive

reactions to a tendency to conform and apply some restraints. Most of the time such phenomena are episodic and confined to small portions of the session, appearing here and there amidst material which still handles themes of distrust, challenge, and the fear of closeness. Later on, perhaps toward the end of the second year, one observes in spots the appearance of trends characteristic of normal adolescents. For instance, boys who had little if anything to do with girls (and if so, girls were treated with contempt and as a means to an end) begin to show an interest in dating. In girls, similar changes are reflected in concern about their appearance. One girl, who in the beginning had been reluctant to see herself on the screen in movies of the group, remarked, "I look much better put together than I feel inside."

CONTACT WITH THE FAMILIES

Mrs. Packard undertook the arduous task of becoming acquainted with the parents of our group members. It was clear from the beginning that she could not sit behind her desk and await a procession of anxious fathers and mothers eager to find out what had led their children astray and willing to talk about themselves. On the contrary, the technique of what is sometimes called "aggressive case work" had to be applied. A number of different diagnostic categories could be recognized among the parents. While it was not possible to carry out formal evaluations, a few visits generally allowed Mrs. Packard to form an opinion as to the assets and liabilities of a particular parental set. Plans for long-range intervention were then made accordingly. The individual strength of each parent, the cohesion of the family, the relationship with the children, and many other factors determined whether work would be directed toward maintaining and strengthening the family ties or toward helping the child to leave an environment where nothing but further damage could be expected. The latter instance involved parents with a primitive ego organization, a strong narcissistic orientation, and poor integration of aggressive drives. Such a constellation frequently results in the child being forced to act out the parents' impulses; since the child's ego is also poorly integrated and insufficiently developed, it is vulnerable and easily influenced. The mother of one of our girls, for example, characteristically kept the daughter in the house during Saturday and Sunday but would allow her to go out shortly before the appointed time for her return to the training school. Such a maneuver appears to us to represent a classic example of a child acting out his parents' impulses. At the other end of the scale is a family which has remained fairly cohesive: there has never been any separation nor talk about it, even though three of the children were brought before the Juvenile Court. In this instance, it was possible for Mrs. Packard, over a period of two years, to

encourage the mother to look at her past and to recognize some of its connections with the present. In due time she became aware of the complications created by her insistence on boarding infants in the home. Her son, who was in our group, had not so much acted out for his parents as he had expressed his own resentment and frustration in aggressive acts. Still another situation prevailed in the case of a divorced woman, the mother of one of our girls, who showed considerable improvement chiefly through identification with Mrs. Packard; unsuspected assets have appeared in the course of time, and her periods of sobriety have lasted longer and longer. Different dynamics were recognizable in the case of a 17-year-old boy whose mother was openly seductive. The boy sought protection by effecting his removal from the home by becoming involved in antisocial acts. It became apparent that this woman's girlish ways—wearing shorts and bobby socks and taking a group of teenagers to the beach frequently—were a reaction against masculine identification and fear of closeness with women. One of the important results Mrs. Packard has observed in her work has been the slow development of the ability of the youngsters and their parents to communicate better. In this respect it must be borne in mind that there is frequently a delay between efforts in case work and the time when the parent reaches out on his own for help.

DISCUSSION

As is usually the case, working on this project has raised more questions than it has answered. We believe that, in addition to whatever success we have had in rehabilitating the members of our groups, the most important contribution has been the awakening of interest in the people who have to deal with delinquents, both professionals and laymen. Plans are now under way to expand this program chiefly by making available training in group counseling and group therapy to interested people among the training school and probation personnel. We hope that in due time it will be possible to make further headway in combating juvenile delinquency by educating the community at large to carry out successful preventive measures.

CONCLUSION

This paper describes briefly some of the problems encountered in the process of organizing a group therapy program for "juvenile delinquents"; treatment begins in the institution and is continued with the same group in the community. In such a program, careful consideration must be given to the following: (1) Selection of group members. It is important to form a

balanced group. Active as well as passive individuals should be represented. (2) The personnel of the institution should be indoctrinated before treatment starts; they should have ample opportunity to become acquainted with the therapists and their aides. (3) Effective communication with the personnel of the institution as well as with probation officers and the court should be established and maintained. (4) Last but not least, case work with the parents, in which the worker must be very flexible and adaptable, should be carried.

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“FAMILY GROUP COUNSELING” AS DIFFERENTIATED FROM OTHER “FAMILY THERAPIES”¹

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Treatment of the family as an integral group is rapidly coming to the fore, especially as an approach to be considered in the armamentarium of psychotherapies to include treatment of the family as a distinct social system is fraught with potential confusion for “client” and for “therapist” unless there is reasonable clarity as to the organizational level (or levels) of behavior on which the method is being focused. A married man with an acute peptic disorder very likely has neurotic conflicts which could be approached psychotherapeutically; he may also have a very stressful marital situation which could be approached at the level of marriage counseling; but for immediate relief of acute symptom distress, the individual will welcome a therapist who is willing to treat his somatic problem. Having gained relief of his somatic disequilibrium, his goal then may need to be the resolution of some of the related intrapsychic conflicts through individual or group psychotherapy.

Another goal, alternative or simultaneous to dealing with the psychological (intrapsychic) disequilibrium, would be seeking help for the social disequilibrium that undoubtedly exists in his marriage or family group relationships. It is at this latter organizational level that the method of “Family Group Counseling” described herein is aimed.

It is obvious that one and the same individual may be involved in each of the organizational levels referred to above. It is equally obvious that the processes peculiar to each level are operating simultaneously. Although the interrelationship of such levels with each other may well be of the order of interdependence of temperature, pressure, and volume in physics, this does not deny the rationale of developing the theory and technique for a single-level approach. In this regard, we would differ with Ackerman (1962) who takes Freud to task for focusing one-sidedly on the intrapsychic level. Each level of behavioral involvement requires clear delineation of both theory

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² Family Study Project Study Group Staff of Allegheny General Hospital, Pittsburgh. The Study Group as listed above represents the disciplines of psychiatry, social group work, psychiatric social work, sociology and medical social work, respectively. Dr. Freeman is the project director.

and methodologic application. Broadening the traditional therapies to include an additional level can serve only to increase the empiricism involved. At this stage in our knowledge of behavior, we would do better in investigations of therapeutic effect to reduce, rather than increase, the number of significant variables being deliberately manipulated at any one time.

From this point of view, it seems desirable to test a method of family treatment that focuses on group interactive, rather than individual intrapsychic, processes. Freud (1950) pioneered the psychological treatment of individual behavior, basing his method on soundly constructed theory of intrapsychic phenomena. As yet a similar model for the basic social unit—the family—has not been developed. Much valuable theory of small group process has been developed and documented by such disciplines as sociology, social psychology, and psychoanalysis. Several professional disciplines have begun development of the treatment of small groups: e.g., group psychotherapy, social group work, group psychodrama. But to our knowledge none of these disciplines has focused its group theory specifically on the whole family unit as the object of treatment.

FAMILY GROUP COUNSELING

The Family Study Project of Allegheny General Hospital in Pittsburgh, Pennsylvania, currently is testing a modification of social group work method with families. This method is called "Family Group Counseling."

The method involved is primarily sociologically oriented at the level of the external interactions within the family group. Psychologically, the individual family member sets of intrapsychic conflicts are recognized as operative in a very pertinent manner. But they are not, *per se*, the therapeutic focus in this method.

In Family Group Counseling, the counselor strives to provide the family with insight at the social level of external reality; this is achieved by helping the family group to recognize and modify its current major interactive discrepancies (social role conflicts).

This is in contrast to individual therapy and individually oriented group therapy in which the therapist attempts to provide insight at the psychological level of internal object relations by helping the patient to resolve his major "transference" problems.³ With the interpretive help of the therapist, the patient in individual therapy corrects his transference distortions by using the therapist as a relatively noninteracting external object relation. In Family Group Counseling, the family problems are alleviated with the catalytic help of the counselor, employing the very actively

³ "Transference" is used here in the sense of regression to infantile behavior patterns.

interacting relations between and within the family subgroups. The Family Group Counselor works toward compromises of the manifest discrepancies in the overt family group interactions.

The goal of Family Group Counseling is change in the social functioning of the whole family unit, rather than of one or more individuals in the group. Change is effected by means of intervention into the group process, the point of entry being the whole group or significant subgroups. The counselor utilizes the family group as the change agent. He deliberately de-emphasizes the transference relationships by avoiding, wherever possible, unilateral interaction with individual family members. This is in contrast to the individually oriented therapies in which the therapist maximizes the focus on transference reactions as a means of effecting insight leading to intrapsychic change.

The Family Group Counselor's role is to promote, facilitate, and guide communication in the group so that effective communication channels are multiplied and strengthened. The counselor also assists procedurally in problem-solving efforts and goal formulation. Group goals and group functions are central to the counseling process, as distinct from individual strivings. The focus is on social process and the reciprocal relationships of the members as demonstrated by their social role functioning. Emphasis on the external group interactions rather than the individual internalized conflicts is achieved by coordinating group process about a common group problem, the goal being group solution of the problem. Repeated goal-confrontation encouraged by the counselor aims at a conscious alteration of the interactions, and therefore problem-solving.

A SCHEMA FOR DIFFERENTIATING FAMILY TREATMENT APPROACHES

In child-guidance work, emphasis is being placed on seeing important subgroups in the family in addition to the well-recognized mother-patient group, such as mother-father, mother-father-patient, and mother-father-patient-important sibling(s). The latter two groups commonly are referred to as "family therapy." In reading or hearing descriptions of these various approaches, it is difficult to know just what methodology is being employed, and with what consistency.

FIGURE 1

T R E A T M E N T S U B J E C T			
Major focus of treatment method	Individual Only	Individual in a group setting	Group (or sub-group) only
One to One <div>Ego Ego-alter</div>	(1) Traditional Psychotherapies (including psychoanalysis)	(2) Some group and family psychotherapies	
	(3) Traditional social case-work	(4) Some casework Some family therapies	
Group <div>Ego Ego-alter</div>		(5) Some group therapies (including families)	(6) ?
		(7) Traditional social group work	(8) "family group Counseling" Other family therapies?

The schema illustrated (Figure 1) is an initial attempt to provide some kind of framework in which the many different variations of family treatment can be classified for purposes of comparative reference and interdisciplinary communication. At this stage of our knowledge (or lack of same), we should avoid value judgments in comparing the different methodologies.

The basic methodologic differentiation in the illustrated classification is between the "one-to-one" and the "group" treatment approaches. By "one-to-one" is meant any counseling or therapy method in which a professionally trained person treats a patient or client alone, or individually within a group setting in which the majority of verbal interactions is in relation to the professional leader. By "group" is meant any counseling or therapy method in which a professionally trained person specifically and predominantly utilizes the group interactions other than, or in addition to, those involving himself, for therapeutic purposes.

These two major categories are each subdivided into two areas of methodologic emphasis: "ego" and "ego-alter". "Ego"-focused methods, by this definition, are those in which therapeutic interventions and interpretations are made principally at the psychological level, directed at the individual's self-image, whether conscious or unconscious. "Ego-alter"-focused methods are those in which interventions and interpretations are made predominantly at the social level, directed at the "group-image," using the latter term to refer to the group members' perceptions of the overt interactions occurring in the ongoing group (total and subgroups). In the latter (ego-alter), emphasis is on external current (social) reality; in the former (ego), it is on internal psychic imagery and transference⁴ phenomena.

The heading "Treatment Subject" in the schema refers to the "client." "Individual only" is meant literally, as is "Group only." In the latter category, subgroups (dyads, triads, etc.) of the total group, exclusive of the professional leader, are included. "Individual in a group setting" refers to those treatment situations in which an individual patient or client is seen jointly either with other members of the family or other patients, or both, but in which the object of treatment is specifically the designated patient or client.

Probably the most easily classifiable therapies according to this schema are those which deal with the individual only, and with major focus on transference regression (ego). Such therapies would be placed in Box 1 of the schema and would include psychoanalysis and the analytically oriented psychotherapies. Other therapies dealing with the individual only, but with

⁴ See footnote three.

emphasis largely on current social reality problems, fit into Box 3. These include social casework in what is understood to be its generic sense, and some forms of counseling conducted by other professional groups, e.g., vocational counselors. The distinction being drawn between Boxes 1 and 3 is essentially similar to Slavson's delineation of psychotherapy and counseling. Slavson (1960) points out that the counselor's major concern is "solving practical problems," whereas the psychotherapist deals with "irrational, infantile feelings." Obviously, few if any therapists practice pure versions of either of these types. Reference in this classification is only to the predominant focus.

Therapeutic approaches which deal with the individual in a group setting are now very numerous and extremely varied. Such approaches, although differing notably from each other, may bear the common label "family therapy." Gralnick (1962) uses an even broader definition of "family therapy" by including all methods in which other family members are seen "either separately or jointly with the primary patient."

When the therapeutic methodology deals specifically with the "one-to-one" relationship, even though treatment is conjoint with others, it falls into Boxes 2 or 4, depending on whether the emphasis is on "ego" or "ego-alter." Thus, some therapists treat groups (including families) as if they were engaged with two or more of the group members simultaneously in separate "one-to-one," "ego"-type therapeutic relationships (Box 2). Others will meet with a group (e.g., marital pair), and although the focus is on "ego-alter" interacts, the therapist manages to avoid methodologic use of group process, dealing with each member as though he or she were there alone (Box 4). With this therapeutic approach, the marital pair not infrequently will tend to follow the therapist's pattern by referring to their spouse in the third person. The family therapies falling in Boxes 2 and 4 usually, although not invariably, have as their aim the treatment of the individual who is designated as the one needing help.

Therapeutic approaches falling into Boxes 5 and 7 include those which use group process as a major methodologic tool but have as their principal "client" a given individual, or a group of individuals seen as individuals. The group *per se* is not the object of treatment in these methods. In group psychotherapy, "it is the individual who is being treated, not the group," according to Locke (1961). Similarly, in a number of the family therapy approaches utilizing group process, treatment of the designated patient is still the major aim. Even in traditional social group work in which the emphasis is on "ego-alter," group process often is applied specifically for the benefit of the individual.

When the treatment subject is the group *per se*, the therapeutic ap-

proach belongs either in Box 6 or 8 in this schema. It is believed to be theoretically conceivable that a therapist might treat a group as *the* client by dealing with individual intrapsychic mechanisms without the primary therapeutic consideration being the individual group members (Box 6). However, clear-cut examples of such approaches have not yet been in evidence.

"Family Group Counseling" as briefly outlined above is designed to be an example of therapeutic approaches classifiable in Box 8. As already indicated, the group is the object of treatment, group problems and group goals are of primary concern, and group process is employed to the exclusion of "one-to-one" therapist-client relationships.

Obviously, it is one matter to conceptualize a specific treatment methodology and quite another to ascertain whether or not it has been put into actual practice. We currently are developing methods of differentiating group treatment approaches so that it may be possible (given a transcription) to determine by measurement the box into which any particular therapeutic approach would most readily fall.

DISCUSSION

Parloff (1961), in an early review of "family therapy," states his belief that "the theory and techniques of family therapy are appropriately different from those found in either group or individual forms of therapy." This is so to the extent that the techniques being compared are in fact different. It is to facilitate just such differentiation that the schema herein described is proposed. The approach designated by the authors as "Family Group Counseling" is submitted as an example of a method that is "appropriately different" in the sense implied by Parloff. As a treatment technique, it may be more or less suitable than the more traditional approaches for various types of family problems. Its appropriateness for these various problems is now under investigation and the effectiveness of its use is being tested by an instrument designed specifically to deal simultaneously with several dimensions of role congruence-incongruence in the family.⁵ It is important to recognize that the entire frame of reference—theory, technique and research measurement—necessarily involves a level of variables different from those ordinarily dealt with in the more traditional approaches. Such a philosophy was emphasized by Mangus in 1957. Discussing marriage and family counseling, he suggested that role theory "became the conceptual orientation through which an integration of theory, research, and counseling may be effected."

⁵ The research instrument is described in the 1962 Progress Report of the Allegheny General Hospital Family Study Project.

There never may be a method in practice which is confined purely to one level. But at least theoretically, there should be as clear a distinction made as is possible. Conceivably, different types of family problems may be more appropriately handled by therapeutic emphasis on a particular level. The more clearly these different levels of therapeutic approach can be differentiated, the more appropriate, and therefore probably the more effective, will be the therapeutic resources that can be mobilized.

SUMMARY

"Family Group Counseling" is proposed as a method of family treatment that focuses on group interactive, rather than individual intrapsychic, process. This method is principally sociological in orientation, rather than psychological. The counselor helps the family group to recognize and modify its current major interactive discrepancies, in contrast to individual therapy and individually oriented group therapy in which the therapist helps provide insight through resolution of "transference" problems. Group goals and group functions are central to the counseling process, the counselor assisting procedurally in the group's problem-solving efforts and goal formulation.

It is suggested that from descriptions of different "family therapy" approaches, it is difficult to know just which methodology (or methodologies) is being employed. A schema for an initial differentiation of these approaches is presented, with the plea that value judgments in comparison be avoided at this stage of our knowledge.

The principal delineation of the classification illustrated is methodologically between the "one-to-one" and the "group" treatment approaches. Additional subdivision involves distinguishing between methods focused at the psychological and the social levels of behavior. Various approaches are further categorized, depending on whether the subject under treatment is an individual, a group, or an individual in a group setting. Thus, eight separate areas of therapeutic emphasis are delineated.

The need to recognize different levels of variables in family therapy is discussed.

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STEPS IN SENSITIZING PARENTS (COUPLES) IN GROUPS TOWARD SCHIZOPHRENIC CHILDREN¹

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As a move toward more effective results in guiding parents to understand and deal with their children in a child guidance clinic, two steps were taken. One was the separation of parents of schizoid and schizophrenic children from those with nonschizophrenic children; the other was that both parents, father and mother, were included in the same group. The latter step was a departure from our usual procedures, which have been described in *Child-Centered Group Guidance of Parents* (Slavson, 1958).

Both empirically and theoretically it is ordinarily considered more efficacious to place fathers and mothers in separate groups and to form the groups on the basis of the sex and the same age range of the offspring. Since all are faced with more or less similar situations and in many instances with identical problems, the parents carry on more focused and aim-directed discussions. This favors more pertinent and relevant interchange. The common interests and preoccupations assist in clarifications and suggestions.

The separation of fathers from mothers is motivated by two considerations. One is that the role of the father in the daily life of the child is vastly different from that of the mother. Of necessity, each deals with different aspects of the offspring's life, both because of differences in the symbolic meaning of each and the difference in contact with the child in point of time and content. Also, the role of each parent is determined, in part, by the sex of the child. This bio-socio-psychological variability needs to be kept in mind in forming and conducting child-centered guidance groups of parents.

In the instance of the group under study here, however, these considerations were suspended, and both parents were included in the same group. This step was taken because we came to recognize that the parents were not cognizant of the real nature of the illness of their children; they were not aware of the children's fragility and limited capacities for school achievement and for establishing social relations. All of the parents, fathers and mothers, made demands on the children far beyond the children's capacities. This unfeeling and insensitive treatment served to increase the children's anxiety, enhancing their sense of failure, worthlessness, defeat, and doom, and intensifying their rebellion and hostility.

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When the parents of schizophrenic children were members of groups which included parents of nonschizophrenic children, the decisions arrived at for dealing with the latter did not apply to their special circumstances. Indeed, plans and insights suitable to the nonpsychotic youngsters proved deleterious when applied to the youngsters under consideration here. As one mother accurately remarked, "The problem with my son seems quite different from the problems of the others."

The six couples who formed the original membership of this special group were parents of four girls and two boys of high school age. To this group were later added the parents of another boy. The problems of the children had a wide range. One girl was schizoid, withdrawn, asocial; one boy was delusional in his conversation; another boy hallucinated on occasion. The girls and boys were being treated in separate groups, except for the hallucinating boy, whom we soon transferred to individual treatment, with good symptom improvement eventuating. The following year the delusional youth was also referred to individual therapy. At the end of the year, one of the girls was removed, on our recommendation, to residential treatment in a school because of the mother's serious problems. The other three girls improved sufficiently for treatment to be terminated, although one was continued in individual guidance on an occasional basis. All four girls had two years of group treatment.

The parents were not told why their group membership was altered from separate groups of which they had been members. This presented no problem since the new grouping was inaugurated in the fall, the beginning of the clinic year. We found the parents cooperative, their attitudes ranging from intense eagerness to moderate interest. In all instances the mothers fell into the former category, as did one of the fathers, while one father was comparatively aloof although he attended all sessions. His attitude was a result of his personality; he was at least schizoid, probably schizophrenic. The father of one girl never attended the group. The group met alternate weeks for ninety minutes.

Note must be taken of the fact that all the parents had been members of "mixed" guidance groups for short periods and were acquainted with group procedure, but they had not been able to concentrate in those groups on their children's special peculiarities and special problems. In the new group the parents were able to agree, after only a brief series of discussions, that the children of all of them were shy and deficient in relation to their peers. Some, including one father, related their own shyness during adolescence, and the mother of one of the girls concluded that she had pushed her 16-year-old daughter too fast in arranging a birthday party for her; the celebrant "went into a panic" when the guests, all girls, sang happy birthday to

her. Another mother reported that her son "burst into tears and ran out of the room" in a similar situation. Several parents disclosed that their children were diffident in their polite talk to strangers but arrogant toward their parents. This seemed a common phenomenon in the families represented in the group. Another more or less common theme among the group members was that the youngsters had achieved, as a result of attendance at the clinic, some improvements in school and in relationships, a few of the youngsters actually having held simple jobs successfully during the preceding summer. Some of the daughters were very attractive but considered themselves ugly. In conversation the boys and girls always stressed their failures and inadequacies, never mentioning their assets and achievements. We called attention to this fact but refrained from explaining it beyond inquiring whether this negative image might not be the result of the parents' and schools' high expectations and demands which the boys and girls could not meet.

This rather threatening question was raised only because it was an extension of what the parents had said concerning "pushing" their children too fast. We followed the cue they gave us, and they were in a sense ready to accept, if not to respond to, this suggestion. One of the more psychologically literate fathers, a welfare worker, Mr. S., wondered if they did not "expect our children to grow up too fast? We resent it when they don't meet our standards." Mrs. C. remarked that her 16-year-old daughter could not even call for a taxi, adding, "I tell her she is grown up enough to do it, and if she can't (use the phone), then she does not need a taxi." Mr. and Mrs. S. reassured her that "clumsiness is part of growing up. All of us were like that at one time, and all kids are like that." Mrs. C. remained adamant, however, saying, "I can't treat her like a baby all the time." When Mr. K., the father of a boy, suggested that "too many things are turned into an issue," Mrs. T. reported that when she yells at her daughter for three days, the girl will do what she wants her to do but "then she is back doing exactly what she used to do before."

The leader here took the first step toward sensitizing the parents to the uniqueness of their children, saying: "There seem to be two trends in the discussion. One is that our children are still very dependent, very much like babies. At times we are not aware of this and make too great demands on them. They appear frightened by it and, in a sense, they say to us, 'We can do nothing, expect nothing from us.' We would not be impatient if a small child fussed and said no, but we would expect him to do things and we would help him by being kindly but firm and ignoring his fussing. On the other hand, there seems to be a tendency to treat these children as though they really cannot do anything for themselves, and we are so helpful that it reinforces their convictions of helplessness."

At the next session, two of the mothers elaborated on the defiant withdrawal of their girls during the preceding weekend. One girl had gone to her room and spent almost the entire weekend there by herself, "probably day-dreaming"; the other mother described her daughter's reluctance "to participate in the family." Mr. and Mrs. S., on the other hand, reported remarkable "reasonableness" on the part of their son in a particular circumstance, whereas they had expected great resistance. Mr. S. concluded by saying that the incident led him to believe that "we really do not know our children."

We explored with the group the manner in which the parents asked or ordered their children to do things in the home. It was obvious to us that the parents' authoritarian attitudes and impatience aroused rebellion in their hostile and angry offspring. We therefore decided to raise the question of how their mates would respond to the same tone of voice and peremptoriness. This stopped them all. As the question was bandied about by all the members present, they became aware of the inappropriateness of their approach and explored better ways of dealing with the children. However, the solutions were largely in the area of devices and artifices, rather than subjective attitudes. Suggestions such as posting notices on the family bulletin board were made. One of the fathers suggested that "perhaps because we always tell our children no, they always tell us no in return." Mrs. H., whose daughter spent the entire weekend in her room, offered an important observation at this point which we utilized later. She observed that her daughter seemed to "structure" the days for herself. Perhaps, she said, this is a key to the "management problem." This was not picked up at this point for we felt that the parents did not as yet understand their children enough to apply such an approach beneficially, for structuring may be used in the service of domination. The session ended with Mr. S.'s statement: "We have to try to understand why they (the children) don't want to do anything. If we could understand this, it would be helpful."

We considered it our chief task to bring this understanding to them.

At the next session the parents talked about their children as over-reacting, repressing feelings, and having no confidence in themselves. They tried to trace the causes for this in the children's backgrounds. At this point, we pushed forward our idea by stating that while there undoubtedly were relations in the home that contributed to the children's difficulties, the fact could not be overlooked that some children are born more sensitive than others and what seems like over-reacting is actually the nature of the child and he cannot control his behavior or do better.

One of the mothers responded to this immediately, stating that this was certainly true of her child and quoted a number of instances to con-

firm the leader's assertion. After considerable group discussion, Mr. K., who was not too perceptive a person, said that he felt that "it is true that our children are extremely sensitive" and proceeded to say that sometimes when he asked an entirely innocent question, his son considered it as a critical statement. Mr. C. interpreted this as a means of getting attention, but his wife definitely disagreed. She elaborated on this and ended by saying: "It is almost as if these children need to punish themselves." Mrs. S. jumped in and exclaimed: "This need is a tremendous one on the part of our children!"

In their own way the parents had recognized three major mechanisms of the schizophrenic: hostility to parents, their paranoid quality, and the self-destructive urge. Understanding of the nature of the children was carried further by Mr. K., who, in contrast to the earlier extreme pressures he placed on his son to achieve higher school grades, now expressed his gratification with his son's being placed in a class of retarded children because "the pressure has been removed from him and he is actually showing responsiveness to other people, which he did not before." He added, but without rancor, "It is still true that he does not do anything in school."

In a later session the same father calmly stated: "He (the boy) is immature and frightened, and to remain in school for another year and a half where he does not feel stigmatized and where really nothing is expected of him might be helpful, because things are happening to B." He then narrated a "very satisfactory and helpful conversation" between the boy and his parents. Mr. K. was elated as he added, "He has never opened up, never talked to us the way he did this time. This is the first time a wedge has been established in the wall of silence between B. and me."

Mr. S. pointed out that what was important in this development was that the son had sought out the father. The leader reinforced this thought by stating that the youngsters under consideration were extremely fearful; they were afraid to come to the parents with their problems. The leader emphasized how important it was for the parents to establish themselves as "friends" in the eyes of their children.

Mr. C., who was rather punitive toward his borderline and very disturbed daughter, followed this statement up with: "Perhaps we don't give our children enough support. When they were young we acted as judges, always deciding for them what was right and what was wrong. Perhaps what these children need is our support and not our acting as judges." Several parents, in a wave of confession, then spoke of losing their tempers or showing irritation with the children because they seemed to be unable to do things on their own and constantly demanded help.

At the next session, Mr. S. suggested that they talk of other topics than

kids—he was “sick of talking about kids”—but he soon turned to his wife and asked her to report on their son. M., said his mother, had extended his money-earning activities and was getting on well, but had difficulties with his Spanish teacher. The mother was called in by the school principal to discuss this. The mother had observed the Spanish teacher before and found her a woman “full of rage. She walked up and down the room like a caged lion. . . . For M. this must be an upsetting experience.” She did not blame him for his reaction to this teacher, she said, and when the principal asked her to see her son’s different instructors, she refused, stating that it was up to him to coordinate their work with respect to her son. He backed down and promised to follow up on the matter. She ended her recital by saying: “This is an indication of the change in me. Ordinarily I would have gone and exposed myself to all the unpleasantness. Now I was able to let my disgust come through.” Both parents agreed that they were “different people” since coming to the group. Having reduced their child’s dependency on them, the parents too had become less dependent.³

A rather extensive discussion ensued at this point in which all the parents described their children’s reactions, which led Mrs. C., the least understanding of the mothers, to conclude, “I guess our children are all alike.” When the discussion veered to the children’s irritability, Mr. K. described his feelings when he returned home from his office. He anticipated problems and when he saw, perhaps, a coat lying out of place, he at once lost his temper. “Maybe,” he said, “B. is reacting the same way.” Mrs. C. made the point that children need time when they come from school to “readjust themselves from the outside to the home” and that parents needed to give them time and not pounce on them with questions and suggestions as soon as they entered the house.

This thought was reinforced by the leader and concrete suggestions were made as to ways of receiving the children and helping them to re-enter the family arena without too great strain. Suggestions of the same nature had been made before, but apparently without lasting effect. Recognizing the importance of this, we decided to take up this matter again as a planned step toward furthering understanding of the children’s intrapsychic structure. The leader accordingly said at the appropriate time: “Some of these youngsters harbor a great deal of hostility toward us. This is part of the nature of their problem. When they express anger and we become upset by it, we only intensify their anxiety and thereby increase their hostility.” Thus, the third characteristic of the schizophrenic syndrome of which the parents were by now aware, hostility, was brought to their overt attention (Slavson, 1961).

³ One of the chief functions of the leader of a parents’ group is to demonstrate by his conduct the attitudes he wishes the parents to adopt toward their children.

Since they had all experienced the underlying hostility of their children, this statement evoked universal response. Mrs. K., however, was puzzled by the fact that when she called B.'s attention to his anger, he always told her that he was not angry. The leader explained that in the children they were discussing, anger was so much a part of them that they could not recognize it, which, the leader added, was true of their other feelings and reactions as well. One of the mothers concluded from these remarks that parents "*should not take these outbursts personally.*"

Five sessions (ten weeks) later, the parents brought out a number of common characteristics in their children: they played with children younger than themselves on an immature level; they were unable to relate adequately to their age peers; they became compulsively absorbed in a single interest; they lacked control, etc. Here we played another trump card, as it were, a strategy of pivotal importance. The leader suggested that perhaps these children were born *with some lack* that made it impossible for them to grow the way other children did. Mr. B. reacted to this by saying it made him think of his (delusional) son. When he was a small child and was bounced up, instead of showing fear as young children usually do, he would stretch out his arms as though he were going to fly, "as though he had no reflexes, as though his wires were crossed somewhere." Mr. S. wondered whether there was "something physical lacking" in these children. Mrs. C. remarked that sometimes she felt that this was the case with her daughter.

The leader exploited this newly emerging awareness by putting forward the idea that there was a possibility of an actual physical or biochemical deficit in the children, that there was "something lacking at birth, perhaps something chemical." It was suggested that the compulsive activity to which the parents often referred was a way by which these youngsters kept themselves together and interested in at least a part of the reality around them.

At the same session, love was one of the themes, and various episodes relating to it were described by several parents. Mr. S. narrated an incident that had puzzled him. His son wanted a special object for his hobby collection that could be obtained only in Manhattan, and the father suggested that M. go along with him since he too was going to the city. M. asked his father whether he would go with him directly to the store and was told that Mr. S. would have to stop off first to see his own father, who was ill. "Never mind," said the boy impetuously, "I'll go to New York myself. You don't really want to take me. You do it only because you think you should." Various suggestions were offered by the others in the group as to ways of dealing with this reaction, none of which seemed to be appropriate. The

leader again emphasized that this response was a result of deep-rooted insecurity, a feeling of worthlessness, of being unworthy to be loved, and, above all, of an inner emptiness, a longing for love. Wasn't M. saying, "You do not love me," or, "I do not feel you love me"? What helped children like M., the leader continued, was consistent acceptance and respect, along with a degree of firmness that would not outrage them but instead would support their weak egos.

Out of a clear sky, Mr. B. asked: "Is it possible that food is equated with love by these children?" When asked by the leader to explain, Mr. B. reported that for the first three months of his life, his son was starved because the doctor insisted on breast feeding. Finally, on their own, the parents put L. on a bottle, and he took two bottles at a time. When asked why this situation was permitted to go on so long, Mrs. B. said, "That was the trouble. He was a very quiet child and could not communicate like other infants by crying. I still cannot communicate with him even now. It is part of an inborn lack in him."

At the next session, Mrs. K. reported that her daughter was resisting attending her therapy group, ostensibly because she had some extracurricular activity in school "which means a great deal to her." Mrs. K. said that because of what she had learned in the group, she had decided not to make an issue of it. (The girl continued as a member of her therapy group without interruption.) At the same session, Mr. and Mrs. H. reported that their daughter was "more cooperative" at home. The mother had talked to the girl "woman to woman," admitting that she, too, had negative feelings about some of the household chores. This admission seemed to have a salutary effect on the girl. The mother recalled that her daughter had once said to her: "When you see me neglecting my room, why don't you do something drastic?", and she concluded that, "Maybe she wants me to be direct with her and ask that she participate in the family."

The leader asked the group whether they could explain why this talk with the girl had had such a good effect, but none could suggest a reason. The leader then asked: "Could it not be that it was because Mrs. H. talked with P. in a friendly, though firm, manner and did not command her?" Mrs. H. at once recognized that this may have been the cause for the change in the girl, and Mr. B. added that, "Sometimes the right thing said at the right moment can do wonders."

During a discussion about the irritability often displayed by the youngsters, Mrs. K. affirmatively said that observing her daughter and the apparent unreasonableness of her reactions convinced her that it must be "physiological," and Mr. S. expanded on the subject and ended by saying, "When these children are the least lovable, they need the most love from us,

because they cannot control themselves." (Later it was necessary to clarify that loving did not necessarily mean being maudlin, that these youngsters, because of their ego weakness, required firmness as part of loving.)

At another stage in the interview, when excessive eating by a few of the youngsters was discussed, Mr. S. made a statement revealing a rather deep understanding of the nature of the youngsters under consideration. He said: "These children seem to be empty and this is an emotional thing, and, in a way, when they are given food, they seem to take out of it the feeling that the parent is giving along with the food and that is perhaps what calms them down."

In a discussion of the uncontrollable temper of some of the children, Mr. B. described a scene in which his younger daughter (not a patient) in a fit of temper threw herself on the floor, screaming and kicking. Instead of becoming enraged and punishing her as he would have reacted in the past, Mr. B. lay down next to her and went through the same motions. The girl at once stopped, looked at him, and said, "Daddy, you look silly." "Well," said he, "that's the way you look." She had never thrown a tantrum since. The leader drew a parallel here between this episode and another with the older brother, our patient. In the latter the father had lost his temper and become punitive, while with the girl he had controlled his irritation. As a result of this comment the parents concluded that, "To help our children we must learn not to break down."

As an illustration of the parents' increased sensitivity to, and understanding of, their children, the following is taken from a discussion by the parents at the twelfth session. In previous sessions, Mrs. C. repeatedly complained of her daughter's talkativeness. At this session, she again remarked that her daughter talked a great deal. The leader now asked why the girl had a need to talk so much. Mrs. C.'s response was: "P. may be talking so much in order to avoid talking about her problems or listening to the problems of others because this may arouse her feelings of anxiety." She wondered whether it would help if she explained this to her daughter. Her husband quickly responded by saying: "I don't think it would do any good. I act in the opposite way. When I get disturbed or anxious, I withdraw into myself and keep quiet; P. chatters. I don't see any point in pointing it out to her." Mr. S. agreed that the chatter was a "defense against things that bother the girl." Mr. B. stated that he, too, did not see any value in discussing it with the girl. "She would only take it as a criticism," he added, and later described that when his mother had done this to him, he had felt she was "picking" on him. Mrs. C., however, continued to adhere to her conviction that talking with her daughter was the right approach. The leader asked if her admonitions to her daughter had ever been effective, and Mrs. C. admitted that they had not.

Mr. B. raised the question: "Don't we point out too much the things that are wrong and not enough the things that are right?" He said he believed that the difficulty with their children was that "they are too much absorbed within themselves and take certain things for granted." The leader supported Mr. B. in his assertion and elaborated on the egocentricity of the children under consideration. Mr. S. joined in the conversation and remarked that it was really unfair to be critical of these particular youngsters because they "really cannot help it." He then narrated a rather significant episode. His son (a marked borderline case with bizarre behavior) played with very young children, and Mr. S. and his wife used to go out and chase the younger children away. However, after the discussions in the group, they decided not to interfere, and the boy continued to play with children seven and eight years his junior.

One day a woman accosted his wife and complained of their son hurting her boy. Upon returning home, Mrs. S. told her son of the incident and explained that she and his father did not object to his playing with young children if that was what he wanted to do but that it was embarrassing for her to get complaints about his conduct. M. responded that he himself did not understand why he played with younger children. "It must be an escape," he said. He then asked his mother if she did not ever want to escape. She explained to him that everybody does at one time or another and that she herself often did but that it was not usually a good idea. She gave him an example of a practical situation in their family life in which escaping from doing an unpleasant task would bring immediate relief but in the long run would entail even more difficult effort. She added that she realized that as he watched young children playing in front of their home, he must think what an easy life they had and that he would like to be like them and have it easy too. The son seemed to accept this, but asked why the children involved should have to complain to their parents. The mother explained that, being little, they could not deal with the situation and sought their parents' help. The boy thought for awhile and then said that he would not play with little children any more. In talking to Mr. S. about this incident, the boy ended by saying, "After all, there's a difference between those kids and myself." Since that time the boy had never again played with young children. "It worked like a charm," Mr. S. said.

Mr. B. attributed the outcome of this episode to "timing." "If you say it at the right time, it works," said he. The leader questioned whether it was the manner, the approach, that might not have produced this desirable effect, rather than the timing, and whether the changed attitude of the parents was not the deciding factor. There were some differences of opinion on the matter, which ended when Mr. S. said: "This is a common problem with all of us. We cannot seem to ignore (overlook) anything our children

do. We have to regulate and push, and this doesn't really help them at all."

As the girls' therapy group progressed,⁴ Mrs. C. noted that her daughter had become more sensitive to other people's feelings, whereas in the past she had seemed oblivious to them. Mrs. M. reacted to this by saying that, "Some of these children feel unloved even though they have been loved a great deal." Since joining the group, she remarked, she had tried to be less critical of her son, C., and found to her surprise that he began to laugh and sing, "something he had not done for a long time." Mrs. B. reported that her son had made "great improvement." When he first came to the Center, he had had no friends but now he did and he seemed to be having fun. Mr. B. added that, "L. not only has friends, but his two best friends happen to be the top students in the school." Mrs. H. described how her daughter, who had been frightened and shy, now hurried home on Fridays to do her homework and then, quite on her own, traveled to a nearby city by train to spend weekends with her aunt where she participated in group activities with other adolescents in the community. "It took P. a long time to get to this point," added Mrs. H. Mrs. C. remarked that when she told her daughter that she seemed to be "getting better" in her relations with other girls and suggested that she might like to invite some of them for a weekend, her daughter said, "I'm not ready to do that yet," indicating that as the parents had acquired insight into their daughter, the daughter as well had acquired insight into herself.

It must be especially noted that the attitude of all the parents in the group toward their children has grown more benign. The parents have made an effort to understand empathically; they have reduced their expectations for achievement, become more supportive and more sensitive to their offsprings' inner weaknesses and struggles, and have conceptually recognized the basic personality difficulties and the dynamics of the schizophrenic process. All this was achieved without directly naming the malady or describing its nature. Instead, the parents were aided in arriving at conclusions based on their own observations. This was achieved with guidance from the leader and through their interactions with one another in the group.

⁴ The children of the parents in this group were treated in groups with nonschizophrenic youngsters. Boys and girls met in separate groups.

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EXPERIMENTATION WITH GROUP TECHNIQUES WITH EGO-DISTURBED MOTHERS

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At the Child Development Center for the disturbed preschool child and his family, various types of groups have been used for therapy with parents. For many years we have been concerned with the problem of how to help ego-disturbed mothers and fathers, who presented particular needs and demanded special conditions of work not available in the usual groups. Experimentation with techniques in a group of ego-disturbed mothers at the Center for a period of three years led to the methods and results reported in this paper.

The group included seven mothers of emotionally disturbed children who were patients of the Center. All of the mothers had conflicts of pre-oedipal origin and had psychotic or borderline parents. While they had many of the symptoms of neurotic patients—phobias, obsessions, anxiety states, depressed feelings—they also exhibited weak ego structure and disturbances of ego functioning. One mother showed evidence of confused thinking and had violent outbreaks of aggression toward her children. Reality testing for many was poor. Mrs. B. had the feeling that if she talked hostilely of her mother the latter would know what she was doing. Mrs. W., obese and with poor impulse control, at times showed paranoid features. Mrs. H. had extreme mood lability and poor ego boundaries, identifying too easily with others. Her obsessive concern with understanding her “oedipal conflict” masked deficient reality testing, which was manifest in the distortions she presented to her children about sex. Mrs. C. had severe mood swings, precipitated by minor environmental happenings. There was for all the mothers marked disturbance in object relations, so that they had no real friends and were overly aggressive or withdrawn. Some were socially isolated. All manifested more nonverbal behavior than we had observed in patients with diagnoses of neurosis or character disorder; this behavior was expressed in much facial grimacing, bodily posturing, restlessness, and later, in the group, in other forms.

Some of the mothers, prior to joining the group, had been in educational groups of limited duration, and some were in individual guidance relationships. These measures had not been sufficiently effective for therapeutic influence. The decision to place these mothers in another type of group involved many factors. We had observed in the educational groups that these women were unusually eager to be in the group and when it

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came to an end they demanded more. Their response to its termination was that of a deprivation, and, conversely, their inclusion was a satisfaction. There was an intense seeking and longing for the experience, even though a limited one, evident in their coming to sessions at night, from appreciable distances, and in thunderstorms and blizzards. We therefore thought that we would experiment to evolve a form of group treatment geared to individuals with the problems described.

We had found that the methods of the educational groups were not in the service of the maturation of such parents and in some measure even interfered with it. These mothers, whose histories showed marked oral deprivation and whose personality structures indicated their strong unresolved oral conflicts, although intellectually motivated to help their children, could talk in the group only of themselves and their needs. Educated and fairly sophisticated, they did know the principles of child-rearing superficially, so that guidance, individual or group, served to emphasize the discrepancy between the standard and their failure. With mothers with such unsatisfied needs, such guidance is too much orientated to the child and therefore is experienced as a personal deprivation.

The method of group treatment which we had found useful for patients with character disorders, which we reported in other journals (Sands, 1956, and Sands and Strean, 1960), was not suitable for this group. This method depends on fostering group interaction as a step to self-examination; for those with character problems, where defenses are rigid and self-examination often minimal, mobilization of conflict is part of the group process. Our mothers, with their severely damaged self-image, could not be exposed to the same method.

There appeared to be a contradiction in placing these mothers in a group at all. With their early and perhaps irreversible trauma, there was a strong need for individual gratification. We hoped that what appeared to be a disadvantage and a source of disappointment would actually work to our advantage because the group, with its reality-oriented social structure, can impose limitations on the fantasies and demands which often make the individual experience too intense.

The poor capacity for object relations of these women also seemed a contraindication for group treatment. We questioned if we could expect those with such impaired capacity to form a group and to relate to each other in a way that would effect conditions for therapeutic work. We relied here on the opportunity afforded by a group for fragmented identification, for relating to or identifying with a number of individuals, a situation that does not exist in the one-to-one treatment relationship.

We began our group with a plan for thirty-five weekly sessions, the

duration of a school year. Our planning was experimental, but we thought that this longer duration (than the educational group) would give these narcissistic mothers more opportunity to talk about themselves than they had had in the previous group experience, that they would use each other for gratification, and that a positive transference to the therapist would carry over into improved handling of their children. The structure of a limited number of sessions represented our awareness of the difficulties and perhaps dangers in attempting to evolve a therapy group for such patients, and also our timidity in embarking on our experiment.

The aims and expectations described above were swept away in the new group situation with which we were confronted. In the torrent of feelings which were unleashed it was as if we were attempting to guide an ocean liner across rough seas with the charts and instruments used for a small motor cruiser. We found, with these mothers, a much intensified demand for the reliving of a family experience, a strongly expressed wish for parental care, exaggerated sibling rivalry, and an abnormal hunger for parental gratification that we had not observed in other groups. We saw marked regressive behavior, manifested at home and in the group.

We observed that almost all areas of living and parent-child relations were conflicted. With parents whose pathology is of such early origin, there is a pervasive immaturity, a preponderance of infantile behavior, so that everything is difficult and they cannot find a solution to even an isolated problem. With some, the intensity of their relationship to the therapist came out in increased helplessness and dependency and more self-depreciation.

They could not come together on a theme, and amplify it, as we usually expect of a group. Their rivalry for the therapist, their urgency to capture her attention, their demand to be heard, interfered with the ability to separate the theme from their immediate emotional needs. They craved the climate of individual gratification, and this craving interfered with the thinking and elaborating of a group discussion. Evidences of higher forms of functioning were washed away in the surge of an earlier form of seeking for the object. Thus the therapist was described by one mother as "a large soft piece of clay, round, with no sharp points; all of us can touch you, can put a finger in you, and you'll give." They were in many ways like the orally deprived adolescents in groups described by Stranahan, Atkin and Schwartzman (1957), having a hunger for the attention of the leader.

The intensity of the transference, a transference which manifested their primitive needs, was baldly and swiftly expressed. By the fifteenth session the therapist was referred to as "mama." Symbolic of their hunger they brought candy to the meetings. They vied with each other in describing the horrors of their life histories and their life situations, each one at-

tempting to make her history more traumatic. They came to sessions with eye infections, sprained legs, bandaged arms, seeking and enjoying the attention secured by illness. They elaborated sexual wishes and fantasies to show how "bad" they were, testing to see how the therapist would respond. Infrequently, when the group was smaller because of absences, those present welcomed the change; five was better, four was still better, to be the only one was the wish. Lost in a kind of emotional limbo they sought for boundless love and borrowed strength; thus, to such women the "ideal husband" was "loving, permissive, leading you and you follow because he is strong."

The "pull" upon the therapist by seven young deprived "children," all screaming of their dire plight and all wanting to be heard, the ineffectiveness of either neutrality or reassurance, the constant quest for promises that the therapist and the group would continue forever, demanded tools that were not readily at hand. A crisis came in the twentieth session when their rivalry with each other and their anger toward the therapist were so intense that they could not join together for their usual after-session coffee hour. They expressed fears of abandonment by the therapist in the form of fantasies of parental rejection and fears of the Center and other Center therapists.

We were faced with the task of finding techniques to handle the transference, the intense dependency needs, and the extreme rivalry. In seeking a method of work many critical questions were involved. We understood that while techniques orientated to strengthening the ego alone were not sufficient, there were risks with such patients in permitting instinctual wishes to emerge, thus fostering regressive phenomena. As Knight (1954), writing of patients such as ours, has noted, "The over-maternal, over-permissive therapist may encourage regressive tyranny in the patient by meeting too many needs, while the overly detached therapist may put his patient on what for this patient is a starvation diet."

Our chosen method of work permitted instinctual needs to emerge and permitted regressive phenomena. We reacted to the regression, not with interpretation, but with a certain degree of gratification. We combined gratification with ego support and efforts to strengthen ego organization. We did not wholly ally ourselves with the ego against the instinctual drives, but made, as it were, a combined effort. This course was not undertaken without trepidation; we knew the difficulties that would be involved with such patients, in such a situation, in tempering and handling regression and gratification. How to gratify, how much to gratify, how much regression to permit, how to stem regression, in specific terms of group techniques, were our tasks.

We learned that the therapist had to be particularly active in such a group in helping the members to verbalize hostile feelings, which were expressed in regressive, nonverbal behavior; this often necessitated more one-to-one contact than is usually encouraged in a group. There was much more nonverbal behavior in this group than in our other groups, evident in excessive smoking, much bodily moving, vying for seats near the therapist, turning away from the therapist, loud gum chewing, restlessness and withdrawal, usually occurring when others were speaking of *their* problems. While individualization of interchange between therapist and patient interfered with group development, it provided a gratification which our patients craved.

There were other techniques and ways employed to provide the gratification that helped our mothers to feel that they were receiving individual interest, care, and understanding. During illness or absence the therapist telephoned or wrote a letter before hearing from the absent member. Absences and illnesses, and threats to stay away, particularly in the beginning, were often a testing of the therapist and a demand for her love, and letters and calls were utilized therapeutically. Sometimes the telephone calls were lengthy. A letter, specifically timed, was sent during the latter part of vacation, advising of the resumption of sessions, although the mothers had been given a definite date for return; in June, before vacation, they already clamored to know when they would get "the letter." Sessions that fell on holidays were always made up. The first group gift to the therapist was a little box with "amour" printed on it, along with the request that no one new be added to the group. The bringing and eating of candy was permitted without exploration of the underlying conflicts. Scheidlinger and Pyrke (1960) have reported, in their work with a group of mothers with severe dependency problems, of the necessity of providing gratification by the therapist.

Seemingly a contradiction in light of the type of patient with whom we were dealing, but actually an aid to the working group, we did not arrange for individual sessions. While scheduling of such sessions is a commonplace for most groups, it presented problems for ours. We thought that our patients' regressive illnesses and injuries, their "emergency" problems, might be fostered by having the therapist made available to them individually. Also we were concerned that their vying with each other for the therapist and their extreme rivalry might be encouraged and would be disruptive for the group. The therapist consistently recognized their anger at not meeting their requests for individual sessions. But she did not deny help, instead offering advice or suggestions for using other resources, and utilizing the child's therapist or teacher whenever indicated or possible. With the development of the group there were fewer and fewer requests

for individual interviews and growing insight into their demands for the therapist. Near the end of the first year, when a member asked if the therapist would meet with them individually the next year, the therapist did not have to reply; Mrs. T. followed her request by saying, "I know I want more and more of mother."

We found that we had to permit, for the first two years, in each session, a kind of reliving of a parent-sibling experience in which each had to have "mama's attention." One mother said, "I haven't reached the stage where I am able to be concerned about the others." When there had been a sufficient amount of gratification to each in the form of the therapist's interest and attention for them to get together to work on a theme, then the therapist could take hold of a topic and help the mothers to explore and examine it. The themes of parental rejection, of abandonment, of rivalry were constantly picked up, with the clarification that they were reacting in accordance with the injuries of the past and old realities.

We did not introduce a new member, even when there was room for one and a suitable candidate was found, until the last part of the second year. The intense feeling engendered when we attempted to explore the possibility earlier in the life of the group made it clear that they could not absorb another member until each had more assurance of her place. When a new member finally came, Mrs. W., who feared that when angry she could kill and had had violent outbreaks to her children, said of the new mother that the therapist "wouldn't have let me kill her so I didn't worry about her."

The therapist in this group played a stronger educational role than in our usual therapy groups, giving direct advice and counseling. Often she had to stand for a principle of child rearing or point up the reality of what should be the relationship between parent and child. For example, when a mother described severe beating of her daughter, the therapist set up strong prohibitions and the group followed this, admonishing the mother. While these mothers were not psychotic, the intensity of their feelings, their identification of the problem child with a familial person out of their past, their narcissism, and their poor self-image, blocked their empathy with their children, their ability to "cue" to the children's needs, and interfered with their establishing a satisfactory framework for family living.

One of our techniques was not to stimulate the expression of fantasies. While fantasies and thoughts which were the conscious representations of impulses were permitted to find their way to externalization, as Blos (1953) has written of his work with disturbed adolescents, we did not direct ourselves to secure unconscious material. We permitted regression and offered gratification, but we sought to temper and stem regressive phenomena.

We had learned, in our usual groups, that there was less expression of unconscious material and transference phenomena than in intensive individual treatment (Golden, 1953), and we endeavored to secure fantasies to counter the reality-orientated pull of the group environment. But with these mothers the fantasy-reality balance was too tenuous to permit attempts to secure fantasies. In one of the earliest sessions, when a mother said she could not sit opposite a mirror, her free associations led to quick lapse into primary process. As Eisenstein (1952), in his work with patients like ours has written, "If the focus of treatment remains as it should on the patient's reality adjustment, we show a minimum of interest in his fantasies and a maximum of interest in his life situation."

We clearly differentiated between interpretation (of unconscious material) and clarification, employing the latter "for those relations and feelings available to the ego's recognition without the analytic process" (Neubauer, 1953). Such use of clarification helped to define and reinforce reality testing and to strengthen other areas of ego functioning. Thus, when one patient, mother of a child born without hair follicles, manifested an obsessive concern with hair, constantly changing her hair style, color, and fashion, no attempts were made to encourage fantasies about hair, nor was there any interpretation of castration anxiety. Rather, Mrs. C., fourth and unwanted girl in a family where only boys had been desired, as she struggled for her place in the group, gradually became aware of her conflicts with femininity and of how her overwhelming, domineering attitudes were experienced in group and family. When Mrs. H. revealed a damaged finger, a joint lost in a childhood accident, her fantasies about loss of part of her body were not fostered, but her self-depreciation, her dissatisfaction, and how these carried over into her relations with her two girls and her husband, were worked on. When the mothers brought out feelings of ugliness as women, their underlying sexual fantasies were not sought; rather, they were encouraged to explore what satisfactions their life situations could offer them as women, wives, and mothers. As Eisenstein (1952) has written, the "actual discontent with the reality of femininity" was utilized.

With the opportunity to express aggressive and libidinal feelings, with care that the expression of hostility not be too swift or too overwhelming, with continual assurance that each one had his place, with the direct gratification of letters and telephone calls, with the nurturing, giving role of the therapist, with the ongoing educative process, we began to see gradual step-by-step changes in the transference relationship and in the interrelationships between members over the period of three years that the group was in session. At the end of the first year, although the pull for the therapist continued, members began to be aware of each other in a different

way, began to "perceive" each other. Tentatively and then more overtly they expressed anger, annoyance, impatience with each other, fears of retaliation, and fears that the group would break up. In the second year, understanding some of the conflicts underlying their tremendous aggression to the therapist and to each other, they began to express need for each other, and dependence, and began to give to each other. In contrast to the wish for a smaller group they expressed anger at absences and disappointment at latenesses.

The intensity of the earlier demands for the therapist abated in the third year of treatment; there were harbingers of this in the mothers' ability to tolerate a period of silence in the group in contrast to the months of contest to gain the floor and the therapist's attention. This new phase of group development was apparent in their tolerance of more flexible seating and in their more realistic appraisal of the therapist ("Mrs. F. is not God. Mrs. F. is Mrs. F."). The group as an entity assumed a new importance, so that their focus was not the therapist alone. For example, when Mrs. T. rambled on and on, to the group's discomfort and lack of interest, and was interrupted by the therapist, Mrs. T. was annoyed that the therapist had not waited for a member to stop her, exclaiming that the therapist was "interfering with the group process."

There were indications of change in self-image, expressed in more acceptance and appreciation of their children and in improvement in appearance, general functioning, and social relationships. There was more freedom in examining their behavior with their husbands, with less projection and less intellectualization than had been evident in earlier group sessions. For some whose environment was less disturbed than that of others or whose family members were less ill, the positive changes were more marked. For all, the group helped them to recognize problems which they had heretofore not been able to see and to acquire insight which they have been able to employ in varying measure.

SUMMARY

We experimented with a group of borderline patients with impaired ego functioning and seriously disturbed relationships with their children, to determine how we could be of therapeutic influence. While the group situation made for opportunities for regression and an intensification of the demand for the therapist, it also set up restrictions and limitations which could be utilized to stem the regressive pull and the pressure for individual attention. Gratification was provided in special ways which we had not employed in our usual groups. The role of the therapist was also special and specific in the use of techniques not necessary in groups with patients

with other diagnoses. These techniques were fitted to our use of clarification, rather than interpretation, and ego strengthening and support of what Gill (1954) terms "adaptive gratifications" rather than working through of unconscious conflicts. We observed sufficient improvement to stimulate continuation of our work and exploration of further therapeutic means for a group of patients for whom the usual methods of work are often not useful.

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SCHIZOPHRENIC FACTOR REACTIONS TO FOUR GROUP PSYCHOTHERAPY METHODS

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In developing explanations of psychotherapy processes, it seems useful to consider the proposition that change occurs as a joint function of the therapist's operations—what the therapist does and says, and the patient's personality—the kind of person the patient is (Glad, 1956; 1956a; 1959; in press).

One way of approaching this problem is to identify behavior constellations by inverse factor analysis and then to examine the dependency of patient behavior constellations upon the operations of the therapist. Having established the differentiating characteristics of the behavior of patients in psychotherapy, it becomes possible to examine particulars of patient reactions to particulars of therapist method (Hayne, 1957). Clinical results and hypotheses will be presented in this report in order to illustrate a research method through the application of specific therapy operations to particular kinds of patients. Quantitative details and further analysis are available (Hayne, 1957).

METHODS AND PROCEDURES

Through a combination of systematic application of four different types of therapist operations and an inverse factor analysis of observed patient behavior in psychotherapy, it becomes possible to make a quantitative clinical analysis of the interdependency of therapist method and patient behavior in contributing to a psychotherapy process.

The patients studied were ten male paranoid schizophrenics. They were selected on the basis of (a) psychiatric and psychological test diagnosis of paranoid schizophrenia, (b) Wechsler-Bellevue I.Q. of average or better, and (c) chronicity of illness, defined by their having been hospitalized for at least one year.

The ten patients were divided into two research treatment groups. Each group was treated by four specifically defined methods of therapist operations and by a preliminary and terminal control condition. Only the first 18 sessions from a total of 33 were analyzed for the present report. The two control and four treatment conditions were defined and applied as follows:

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Preliminary Control (PC)

This consisted of the first three one-hour group sessions on alternate days. During these sessions the two therapists remained as inactive as possible in order to allow the patients to react in their most spontaneous fashion. It was intended to be a neutral period during which spontaneous behavior could be observed. Essentially this period developed into "bullsessions" with the therapists largely excluded.

Terminal Control (TC)

This consisted of the sixteenth, seventeenth, and eighteenth one-hour group meetings on alternate days. The therapists again remained inactive, allowing the patients to respond in their most spontaneous fashion.

Therapist Operations

The four variations in therapist operations are defined as follows (Glad, 1956; 1959):

Relationship Feelings (RF). A therapist's emphasis upon the patient's feelings toward other members of the group. E.g., the therapist might say, "You like me today."

Relationship Roles (RR). A therapist's emphasis upon the immediate interpersonal behavior. E.g., the therapist might say, "You're trying to be friendly to Mrs. T."

Self-Feelings (SF). A therapist's focus upon the patient's feelings without reference to the interpersonal context. E.g., the therapist would say, "You're pretty upset," rather than, "You're worried about Al."

Self-Roles (SR). A therapist's reference to the social meaning of a patient's behavior without regard to the interpersonal context. E.g., the therapist would say, "You're pretty critical," rather than, "You're criticizing me."

Following the preliminary control period, group A was treated in the order: RF, order: SR, SF, RR, RF, TC. Group B was treated in the reverse order: RF, RR, SF, SR, TC, to reduce the effects of treatment variable sequence.

Quantification of Behavior Observations

The Interpersonality Synopsis (Glad, in press) method for classifying behavior was applied by three trained observers. During the research sessions one observer watched through a one-way vision screen and made a process recording of emotional responses of group members. In addition, a wire recording of each session was made. From this recording the two therapists and another observer made group judgments as to the (a) affective tone, and (b) social expressive quality of each behavior unit in the middle thirty minutes of the treatment hour. Categories classified always consisted of a combination of affective tone and social expressive quality.

Thirteen hundred affect-social combinations were possible. Of these only 56 occurred with usable frequency. The behavior components combining to account for these 56 categories may be summarized as follows.

Affective Tones: (a) tense or anxious; (b) depressed; (c) pleasant; (d) unemotional or flat.

Social Expressive Qualities:

(a) Agreement—e.g., a therapist said to a patient, "You're being disagreeable." The patient replied, "Yes, I am."

(b) Critical—e.g., "Why is that guy making it so difficult for me?"

(c) Self-critical—e.g., "I really goofed on that."

(d) Superiority—e.g., "When I was home on the farm I never had the difficulties you're talking about. I used to drive that horse down the field as true as a surveyor."

(e) Inferiority—e.g., "My brother was always right and I guess I just didn't amount to very much."

(f) Avoidant—e.g., the patient might change the subject or simply ignore the others or look out the window.

(g) Friendly—e.g., "That's a beautiful tie you have on, Mr. B."

(h) Self-enhancing—e.g., "It wasn't a complete flop when I did it; in fact I think it worked out all right."

(i) Defensive—e.g., "I'm trying to be objective about this but. . ."

(j) Supportive—e.g., "You're doing fine, keep it up."

(k) Dependency—e.g., "I like the way you run this group and I think we need your help."

Factor Analysis of Behavior

The coded behavior of each subject was tabulated over all conditions of treatment to provide scores for intercorrelating each patient's behavior with that of each other patient. A 10x10 product-moment correlation matrix was prepared and factor-analyzed by the centroid method. Five factors were extracted and rotated to oblique, simple structure. Although the first-order factors were correlated, a second-order analysis was not made, since a principal purpose of the analysis was to provide a basis for assessing behavior and change as a function of the variables in particular kinds of patient behavior factors. The analysis conducted for this purpose consisted of the following steps.

Common behavior components for particular people over all conditions of treatment were identified. Each of the five factors was identified by determining the degree to which behavior components were characteristically high and low for those patients with the highest loadings on each factor. Thus, Factor C was identified by seven types of behavior variables

shared by the two patients with highest loadings on this factor. These behaviors may be summarized as *Disturbed-Antagonistic* behavior. Factor D was identified by five types of behavior variables shared by the two patients with highest loadings on this factor. By contrast with the *Disturbed-Antagonistic* quality of Factor C, Factor D may be described as *Affectively Blunted*. Having identified the factors in such general terms and the specifics which make up the generalization, a quantitative examination was made of how these patients changed or failed to change under each treatment and control condition. The question was, in what ways were the behaviors of the patients who represented each factor modified by each of the systematic and control conditions? For example, was the generalized disturbance and antagonism of Factor C increased, reduced, or unmodified by the Self-Roles and other conditions? Was the generalized Affective Blunting of Factor D changed in any particular condition? Factors C and D will be used for illustration. These two factors are presented because: (a) they are clearly differentiated kinds of personalities; (b) Factor C patients were discharged in social remission shortly after termination of treatment, while Factor D patients did not achieve a social remission; (c) one patient in each factor illustrated was treated in group A, the other in group B. Thus, any sequential effects of the order of presentation of the variables would be unlikely to account for common response characteristics.

Results of analysis of these factors as a function of each treatment and each control condition will be presented as follows:

- (a) The *Disturbed-Antagonistic*, Factor C, will be examined in terms of behavior in general and as a function of each condition (Table 1);
- (b) the *Affectively Blunted*, Factor D, will be examined in terms of behavior in general and as a function of each condition; (c) similarities and differences between the reactions of the two factors will be considered.

TABLE 1

Behavioral Reactions of the *Disturbed-Antagonistic*
Factor to Six Conditions of Therapist Operations

<i>General Qualities of the Factor</i>	
(High)	Disturbed-defensive
	Disturbed-critical
	Disturbed-self-critical
	Disturbed-supportive
	Disturbed-friendly
(Low)	Disturbed-dependent
	Disturbed-avoidant

Preliminary Control Period

Anxious dependency, help-seeking, and self-criticism
Generalized defensiveness

Terminal Control Period

Affectively pleasant agreeableness
Friendliness and agreeableness in general
Critical behavior

Self-Feelings Operation

Enhances individuality—the patients do not behave similarly
Anxiously critical

Relationship-Roles Operation

Anxious supportiveness and dependency enhanced
Dependency in general increased
Disturbed-Antagonistic reactions generally reduced

Relationship-Feelings Operation

Anxious dependency, self-criticism and defensiveness characteristic
Mild degree of pleasant agreeableness
Most typically like the Preliminary Control Period

Self-Roles Operation

Pleasant friendly behavior
Friendliness and agreeableness in general
Disturbed, anxious reactions disappear
Most typically like the Terminal Control Period

Disturbed-Antagonistic—Factor C

Behavior variability shared by these patients regardless of the treatment condition are listed in Table 1. In general, they co-varied in a high degree of disturbed or anxious affectivity, a high degree of defensive antagonistic behavior, a moderate degree of self-criticalness, supportiveness and friendliness, and a mild degree of anxious dependency and avoidance.

Preliminary Control Sessions (PC). It was supposed that the most characteristically psychotic behavior would occur spontaneously during this period. The two patients shared in the expression of anxious dependency, help-seeking, self-criticism, and general defensiveness.

Terminal Control Sessions (TC). It was expected that this period would evoke the most typically adjustive reactions of the patients. Disturbed-Antagonistic patients shared in expressing agreement or acceptance in an affectively pleasant, comfortable way. In general, they were agreeable and friendly.

Changes from the preliminary to the terminal control period may be summarized as the elimination of anxious dependency, defensiveness, and self-criticism, and the development of pleasant, agreeable, and friendly reactions. These quantitative changes are consistent with the dischargeability of Factor C patients shortly after termination of treatment.

We may now examine behaviors characteristic of the Disturbed-Antagonistic factor as a function of therapist operations. We may consider both (a) how the factor consistency was modified as a function of the variables, and (b) how such modifications related or failed to relate to the maximal illness (PC) and the maximal adjustment (TC) periods.

The Self-Feelings approach enhanced the individuality of these two patients. Only one of the seven defining behavior units was shared under this condition. It may be noted that this result is highly consistent with client-centered theory. No generalization can be made, however, that such individualizing effects are relevant to improvement in this kind of patient.

The Relationship-Roles approach eliminated all but three of the seven identifying behaviors. Anxious supportiveness and anxious agreeableness were enhanced. Dependency reactions were mildly increased, while disturbed and antagonistic reactions were generally reduced. This treatment approach, then, appeared to enhance interpersonal behavior of a positive quality, but seemed to emphasize status aspects rather than interpersonal effectiveness.

Relationship Feelings. Under this condition the Disturbed-Antagonistic patients behaved as dramatically as they did at the time of maximal illness, in preliminary control sessions. Anxious dependency was increased, anxious self-criticism was highly characteristic, and the defensive qualities were typical. One typically positive result emerged. A mild amount of pleasant agreeableness—a quality shared by these patients in no other condition except the Terminal Control—occurred.

In general, then, the Relationship-Feelings operation provoked reactions most like those of the maximal illness period, but produced one kind of apparently adjustive reaction—pleasant agreeableness.

Self-Roles. Only two of the seven identifying behaviors were characteristic of this condition. Several other behaviors emerged. Pleasantly friendly behavior was typical, friendliness and agreeableness in general occurred to a high degree, and disturbed, anxious behavior was no longer typical. The Self-Roles operation appeared to evoke the most typically socialized, pleasant behavior of any condition in this study.

In addition, behavioral reactions to Self-Roles were essentially equivalent to those characteristic of the Terminal Control, maximal adjustment period. This similarity in socialization suggests that the Disturbed-Antagonistic schizophrenic is most socialized and adjusted by the Self-Roles derivative from interpersonal psychiatry. It will be recalled that interpersonal psychiatry emphasizes social adjustment as a criterion of adequacy, and that an emphasis upon improvement in socialization is characteristic of the theory. This approach is reminiscent of Robert Burns' poetic desire:

Oh wad some power the giftie
 gie us to see oursel's
 as ithers see us.
 It wad frae mony a blunder
 free us, and foolish
 notion.

Apparently, seeing themselves as others see them, has some therapeutic value for the Disturbed-Antagonistic paranoid schizophrenic.

Affectively Blunted—Factor D

This factor is presented as one which contrasted sharply with Factor C in at least three respects: (1) The patients with high loadings on the Affectively Blunted factor failed to improve sufficiently to be discharged; (2) they were typically like the traditional picture of the Affectively Blunted schizophrenic; (3) they were characteristically "nice" to others, while the Disturbed-Antagonistic factor was characteristically hostile.

Patients exhibiting Factor D co-varied on affectively flat behavior variables, friendliness, agreement, supportiveness, and dependency, regardless of the treatment condition. Generally, these patients shared in a lack of emotional responsiveness.

TABLE 2

Behavioral Reactions of the Affectively Blunted Paranoid Schizophrenic Factor
 under Six Research Conditions

General Qualities of the Factor

(High) Flat-friendly
 Flat-agreeing
 Flat-critical
 Flat-supportive
 (Low) Flat-dependent

Preliminary Control Sessions

Affectively flat in general
 Lacking in dependency seeking

Terminal Control Sessions

Apparently "genuine" friendliness
 Pleasant feelings
 Anxious, disturbed feelings

Self-Feelings Operation

Individuality enhanced
 Flat agreeableness increased

Relationship-Roles Operation

Flat agreeableness
 Flat defensiveness

Relationship-Feelings Operation

Affectively pleasant friendliness
Pleasant feelings
Anxious-disturbed feelings
Most like the Terminal Control Period

Self-Roles Operation

Affectively flat in general
Increase in affectively flat friendliness
Most like the Preliminary Control Period

Examination of behavior variables shared by the patients with highest loadings on the Affectively Blunted factor shows some systematic changes as a function of the treatment conditions (Table 2).

Preliminary Control Sessions (PC). During this "maximal illness" phase the Factor D patients shared in four of the five defining behaviors. All of these included the affectively flat quality. The defining behavior that was missing was dependency seeking. It might be wondered whether this lack of dependency seeking is related to the profound degree of illness in a schizophrenic who is no longer concerned about becoming well again.

Terminal Control Sessions (TC). During this "maximal adjustment" period none of the defining behaviors occurred. The two patients developed pleasant feelings and an apparently genuine friendly interest in others. Anxiety and disturbance, which were previously completely lacking in these patients, now developed.

Changes in the Affectively Blunted factor were from generalized flatness to an emotionally friendly, but anxious, reaction.

The Self-Feelings approach appeared to enhance the individuality of these Affectively Blunted patients. Only one of the five identifying behaviors occurred here. This is "flat agreeableness." The lack of similarity in the two patients is the most characterizing result. It will be recalled that the same result occurred with the Disturbed-Antagonistic factor in this essentially client-centered condition.

The Relationship-Roles approach enhanced "flat" agreeableness and produced "flat" defensiveness.

The Relationship-Feelings approach produced consistencies in behavior in these two patients that were unlike the factor in general, but were strikingly like the Terminal Control (maximal adjustment) period. Affectively Pleasant friendliness occurred, and anxiety and disturbance were generally produced. This approach apparently produced the most dramatic adjustive reactions in the Affectively Blunted factor. Essentially the patient gave up the schizophrenic defense and became both emotionally disturbed and emotionally warm.

The Self-Roles approach produced behavior that was essentially iden-

tical to the Preliminary Control (maximal illness) period. The Affectively Blunted quality was typical. The affectively flat friendliness characteristic of the factor was increased. Apparently, some enhancement of socialization occurred, but otherwise the psychotic-like quality of the Affectively Blunted factor was maximized.

The behaviors of the Affectively Blunted factor patients under the six conditions are summarized in Table 2.

DISCUSSION

It will be recalled that Relationship-Feelings operations seemed to produce maximal psychotic-like behavior in the Disturbed-Antagonistic factor. There we reasoned that the RF approach was least effective in any immediate therapeutic sense. In the Affectively Blunted factor the obverse of this occurred. Under the Relationship-Feelings condition the Affectively Blunted patients became most like their best-adjusted selves in the Terminal Control period. Anxiety developed and pleasant friendliness occurred. When the therapist spoke about the patients' feelings about the therapist and other group members, the Affectively Blunted patient expressed real feelings, including both anxious and pleasant qualities. In addition, a considerable degree of superiority or adequacy strivings occurred. These relationships are summarized in Table 3.

TABLE 3

Comparison of Reactions of the Disturbed-Antagonistic,
and the Affectively Blunted Factors

Similarities

Both role variables maximize some socialization aspects.

Self-Feelings variable produces individuality in patients of both factors.

Differences

Self-Roles maximizes "adjustive" aspects in the Disturbed-Antagonistic factor but does not in the Affectively Blunted factor.

Relationship-Feelings maximizes psychotic reactions in the Disturbed-Antagonistic factor, but maximizes *adjustive* reactions in the Affectively Blunted factor.

We have seen, then, that the Disturbed-Antagonistic patient seemed to become therapeutically "socialized" under the condition of Self-Roles operations. On the other hand, he appeared most "regressed" under the condition of Relationship Feelings. By contrast, the Affectively Blunted patient was also mildly socialized by role variables, but was most effectively modified in his behavior and feelings by the very conditions which provoked the most psychotic behavior in the Disturbed-Antagonistic patient. Some attempt to understand these differences seems in order.

It will be recalled that the Disturbed-Antagonistic patients were already highly emotional. Anxious aggressive behavior was their most typical reaction. In addition, patients making up this factor were dischargeable in social remission shortly after the therapy research was completed. It might be supposed that these patients had not yet resolved their conflicts in favor of a complete acceptance of psychosis. They were still struggling between psychotic and adjustive resolutions of their difficulties. On this basis, it might be supposed that the emphasis upon social behavior helped them to learn more socially effective, mature ways of behaving, and thus promoted movement in the direction of social effectiveness and satisfaction. On the other hand, both Rank's and Rosen's theory of the relationship approach emphasizes its meaning in terms of disturbed emotional relationships to mother. On this basis, it might be supposed that the Relationship Feelings approach might plausibly maximize psychotic regression. We can suppose, then, that Factor C patients were sufficiently close to normalcy that they were able to respond to the therapy in general by re-establishing their more mature social skills and thus resolving the psychosis.

In contrast, it will be recalled that the Factor D, Affectively Blunted schizophrenics, were practically lacking in emotional responsiveness, and neither of these patients improved sufficiently to be discharged. It appears that these Affectively Blunted patients had already resolved their conflicts in favor of psychosis.

On this basis, even though their behavior was socialized under the role variables, no affective involvement developed here, and no striking evidence of therapeutic progress appeared. On the other hand, the "mother-symbolic" operation involved in the Relationship-Feelings approach had dramatic effects. Assuming that these patients had already resolved in favor of psychotic regression, it might be supposed that the mother-symbolic approach revived some possibility of emotional satisfaction and some hope and struggle for recovery. The difference in reaction of patients characterizing these factors is reminiscent of a remark by Rosen that interpersonal psychiatry addresses itself to the adult in the schizophrenic, while direct analysis speaks to the child.

Another way of examining and understanding the process of change in these factors is by comparing the projective test responses before psychotherapy with the responses following psychotherapy. Changes in projective test responses can then be examined in relation to changes in overt behavior. The *Emotional Projection Test* (Glad et al., 1956; Glad and Shearn, 1956) provides a fairly direct approach to this kind of problem. This test consists of a series of 15 pictures of a woman showing a variety of emotional expressions, and a comparable series of a man showing a similar variety of

feelings. The pictures have been standardized for their stimulus value in eliciting attributions of feelings from several diagnostic groups, including schizophrenia. The patient is simply asked to say what kind of feeling or emotion is expressed in each picture. It has been typical of schizophrenics that they respond more with *actions* than with *feelings* when they are presented with this problem (Harris, 1949). It has also been found typical of schizophrenics that they reduce this tendency to see actions and increase the tendency to see feelings as they improve in psychotherapy (Brown and Glad, 1952). Furthermore, fantasy—i.e., attributions to the EPT—becomes more nearly like overt behavior as therapeutic improvement occurs (Neumann and Glad, 1953). That differences in responses to the male and female pictures should be especially cogent in revealing the dynamics of improvement in psychotherapy with schizophrenics makes rational sense in terms of the sex-role confusion of the schizophrenic, and has also been suggested empirically by Thompson and Glad (1952).

It is possible, then, to examine the attributions of actions and feelings to the EPT pictures and to see how these attributions relate to the process of change in psychotherapy. The two factors used for illustration in this paper were examined before and after psychotherapy and an analysis was made of the nature of change in their EPT responses. The EPT responses were classified in the same way as the overt behavior observations. Direct comparisons between EPT and behavior are therefore feasible.⁵

For simplicity, we shall consider changes from preliminary to terminal

⁵ The authors extend their thanks to John S. Miller (1956) and E. Frederick Thompson (1952) for permission to use EPT data developed by them. It should also be noted that the relationships among EPT responses and behavior may be somewhat attenuated by the fact that, while the first EPT's were taken concurrently with the preliminary control period, the second EPT's were taken after 33 sessions rather than the 18 sessions on which the behavioral analysis is based.

TABLE 4

Comparison of Behavior and EPT Changes in the Disturbed-Antagonistic Factor

<i>Preliminary Period EPT Responses</i>	<i>Terminal Period EPT Responses</i>
Actions in general*	Hostile feelings*
Anxious feelings	Depressed feelings*
	Anxious feelings
<i>Observed Behavior</i>	<i>Observed Behavior</i>
Anxious feelings*	Pleasant feelings*
Friendly behavior	Friendly behavior
Dependent behavior*	Agreeable behavior*
Defensive behavior*	Critical behavior*
Self-critical behavior*	

* These items show changes from the preliminary to terminal phases of psychotherapy.

phases in fairly gross terms for the Disturbed-Antagonistic factor. It appears that a combination of male and female pictures gives as adequate a picture of the changes as any more detailed presentation would provide. Table 4 summarized characteristics that are relatively high in the two periods. EPT changes can be examined in comparison with the observed behavior changes.

Table 4 shows that EPT responses change from an emphasis upon actions in general and upon anxious feelings, to an emphasis upon hostile, depressed, and anxious feelings.

In the preliminary control period there is little correspondence between the projective test responses and the observed behavior. We might surmise that the excessive emphasis upon actions is an evidence of disowning projection which disappears as the patients improve in psychotherapy. The anxious feelings attributed to the pictures appear to be a fantasy expression of generalized anxiety which is also present in behavior.

When pleasant feelings appear behaviorally in the terminal control phase, they do not develop in the projective test responses. Behavior in general becomes more comfortably socialized in the terminal control period, while EPT responses express the patients' disturbed, aggressive qualities. To generalize, it appears that these patients became able to act out comfortably their positive feelings and to symbolize their disturbances.

Changes in relations between EPT responses and behavior in the Affec-

TABLE 5

Comparison of Behavior and EPT Changes in the Disturbed-Antagonistic Factor

<i>Preliminary Period</i>		<i>Terminal Period</i>	
<i>Male EPT Pictures</i>		<i>Male EPT Pictures</i>	
Actional		Actional	
Depression		Depression	
Critical actions*		Hostility*	
		Anxiety*	
		Self-accepting actions*	
<i>Female EPT Pictures</i>		<i>Female EPT Pictures</i>	
Critical actions*			
<i>Observed Behavior</i>		<i>Observed Behavior</i>	
"Flat" friendly*		Actional*	
"Flat" agreement*		Anxious*	
"Flat" supportive		Depressed*	
"Flat" critical*		Self-accepting actions*	
		Hostility*	
		<i>Observed Behavior</i>	
		Pleasantly friendly*	
		Pleasant feelings in general*	
		Anxious feelings in general*	

* These items show changes from the Preliminary to Terminal phases of psychotherapy.

tively Blunted factor are somewhat more complicated than in the Disturbed-Antagonistic factor. On the male pictures there is a pattern similar to that in Factor C, that is, there is a relative increase in hostility and disturbance, with a relative decrease in actions in general. On the female pictures there is an increase in actional responses, with a concomitant increase in anxiety, depression and hostility. No consistencies appear in the total responses. It appears that the differences in attributions to male and female pictures may provide an explanation for the psychotherapeutic changes.

From Table 5, it will be seen that observed behavior was modified in *all* aspects. On the male EPT pictures, however, the actional aspect, which we have reasoned is an indication of disowning projection, did not change appreciably. Neither did depression, which might be considered an indication of inadequacy feelings. On like-sexed pictures, then, these male patients apparently did not improve on one major index of paranoid schizophrenia. On the other hand, there was "movement" in terms of an increased consistency in the attribution of hostility and anxiety, suggesting that, relatively, the acceptance of feelings did increase. Furthermore, aggressive qualities attributed to the pictures changed from critical behaviors to hostility feelings, suggesting that the previously disowned hostility—i.e., the expectation that others are aggressive—was modified to an acceptance of these hostile feelings as one's own.

The maintenance of actional attributions on the male pictures can be accounted for by the substitution of self-accepting actions for critical actions. That is, it might be reasoned that these patients no longer expect attack from others, but they still expect lack of interest from others. They have given up their disowning of hostility, but have not relinquished their disowning of narcissism. Congruent changes on the attributions to female pictures support this reasoning. The increase in actional attributions to the female pictures may be considered as an increased disowning of being like a woman. At the same time, the shift from critical actions attributed to the female pictures to affective hostility suggests that conflictual feelings are becoming more acceptable. In addition, the attribution of depression and anxiety to the female pictures in the terminal phase suggests that feelings can be fantasized to some extent rather than avoided as they appeared to have been in the preliminary phase. To generalize, it appears that the Affectively Blunted factor has shifted from a disowning of hostility in like-sexed pictures to an acceptance of that hostility. The patient has shifted from an identification with opposite-sexed (female) pictures to a tendency to disown such an identification. He has shifted generally from an extreme avoidance of recognizing conflictual feelings to at least a partial fantasy acceptance of these threats. Behaviorally, this has made possible some lifting of

the affective blunting and some capacity to experience and express his previously dangerous emotions.

In this light, the Relationship-Feelings (symbolic-mothering) approach might be considered *most effective* for the Affectively Blunted patient by providing him with a partial demonstration that his feelings are not as dangerously alien as he had believed. In this sense, the Disturbed-Antagonistic factor patients could be considered to have responded therapeutically to the Relationship-Feeling condition. It became an opportunity to experience their unacceptable feelings fully and safely, to be their regressed selves without threat. By contrast, because the Disturbed-Antagonistic patients were nearer normalcy than the Affectively Blunted, they were able to show peak adjustment when examining and improving their social roles.

SUMMARY

In this paper, we have explored the proposition that behavior and progress in psychotherapy may be a joint function of the kind of operations employed by the group leader or therapist and the kinds of personality composition of clients or patients with whom the method is employed. It appears that a method derived from dynamic relationship therapy increased affective reactions in these paranoid schizophrenic subjects. Depending on the kind of personality exposed to this operation, "therapeutic" or regressive responses were likely to occur. The possibility was considered that "regressive" reactions to the method could also be valued as therapeutic.

The therapy operations derived from interpersonal psychiatry appeared to have generally socializing effects with these paranoid schizophrenics, but this was considered to be effectively therapeutic only in those patients who were still struggling for adjustment.

Therapist operations most closely representative of the client-centered approach appeared to evoke individuality in these paranoid schizophrenics, but no conclusion could be drawn that this effect was therapeutically relevant.

Finally the relations between fantasy in the Emotional Projection Test and the observed behavior of these patients, in illness versus adjustment, were examined in terms of possible dynamics of personality change. It was reasoned that in a relatively benign case of paranoid schizophrenia—Disturbed-Antagonistic—a fairly simple relation between behavior and fantasy may obtain. When behavior disturbance was high, projective material included the disowned aspects. When behavior included some comfortable acceptance of desired but feared satisfactions, the disturbed qualities were symbolized rather than expressed in behavior.

In the more malignant condition of Affective Blunting, a more complex relationship appeared.

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BRIEF COMMUNICATIONS

A NOTE ON THE USE OF A TAPE RECORDING DURING THE THERAPY SESSION

IRWIN W. KIDORF, Ph.D.

It is quite common to record therapy sessions, through open or hidden recording instruments, for purposes of re-evaluating the session, picking up what the therapist might have missed, and as an adjunct in the training of the therapist. In the following, there will be described a use of the tape recorder which, to my knowledge, has received little mention in the literature.

A group of six adolescent (ages 13-15) boys, almost all of whom had been referred to the clinic as a requirement for their probation from a reformatory sentence, had been meeting for some 10 or 12 sessions. These boys were quite reluctant to talk about themselves, their feelings, or their relationships with others, except on a rather superficial level. A mild type of projection ("it was all the cops' fault" or the teacher's, or the neighbor's, etc.) was common to all of them. These boys came to therapy sessions because they "had to." After a half-dozen sessions, a mildly positive relationship was established between the therapist and the group, and within the group among the boys themselves. They began to test the therapist in a variety of fairly obvious ways. One boy gave the therapist a pack of cigarettes to hold until the following week's session, saying he wasn't allowed to have them at home. Another boy spoke about some escapades in which he had been involved but which were unknown to the authorities.

The therapist felt that he would like to record a session, primarily for his own edification. Accordingly, when the group met, they found a tape recorder on the desk, and the therapist introduced the session by telling them it would be recorded. This brought about a mixed reaction. One boy remarked that all of the sessions had probably been taped secretly, with the tapes being sent to the probation office. Surprisingly (to this therapist), the others grouped together to support the therapist. They pointed out that if the therapist had made secret recordings, there would have been no need to bring the machine out into the open at all. Further, they said that none of them had heard anything from their parents or from their probation officers to indicate that the sessions had not been confidential. This marked the first time since the onset of treatment that the therapist had noted a true "group" feeling. The session was taped, and the group discussion centered around trust, that is, we talked about establishing a meaningful (trusting) relationship with others, marking the first time the group had embarked on any but a superficial discussion. Interestingly enough, but perhaps not sur-

prisingly, despite initial protestations of not wanting to talk in front of a microphone, all members participated quite freely. With about half of the session remaining, one of the boys asked to listen to his voice. The therapist decided to stop the discussion and use the remaining time listening to the tape. There were the usual giggling and laughing as the boys came to recognize their voices, but at the end of the tape one boy made a comment which, to the therapist, signified a real breaking down of his defense. "Gee," he said, "no wonder I can't get along with adults. I sound like a real wise-guy. I'll bet I've been talking like that all along, and they don't like me for the way I talk, and don't even listen to what I say."

Subsequent to the meeting with the tape recorder, group sessions have become more meaningful, there is more verbal interaction between group members, and a more satisfactory relationship seems to exist between the group and the therapist.

A similar use of the tape recorder was made with a group of women with fairly severe neurotic symptomatology. We taped for half the session, and listened for the other half. Two interesting things happened. Dorothy, a young matron who was a compulsive hand-washer and who had developed such fears about germs and dirt that she washed not only her own hair but her daughter's hair three and four times a day, reported an incident in which she and her husband had joked about a divorce. The daughter, overhearing the conversation, remarked that if they did get a divorce, she wanted to go with her father. Dorothy did not display much affect in telling this; in fact, she generally presented a picture of overcontrolled emotionality. However, when she heard the tape, she began to cry. She told the group that listening to herself talk about her symptoms had a greater effect than any of the interpretations offered by the therapist or by the other group members. In subsequent sessions, she has been reporting gradual improvement insofar as obsessive ideation is concerned. Also, during the taping part of the session, Alice made a very pertinent remark, showing a high degree of insight, relative to a statement made by another group member. When she heard herself on the tape, Alice laughed and referred to herself as "Dr. Alice." The therapist remarked that quite often members of the group can make just as significant contributions as can the therapist. In a subsequent session, it appeared that Alice's listening to herself give an interpretation of another patient's statement, plus the therapist's comment, were the major reasons for her deciding to continue therapy. She had, it developed, made up her mind to announce on the day we taped, that she could not see any improvement within herself and was going to terminate. When it was pointed out to her that group members contribute, as well as receive, in therapy, she decided to stay. Since this session she has made noticeable progress.

The above two incidents describing a fairly unique use of a tape recorder during therapy sessions represent, of course, the use of a "gimmick," and, as is the case with gimmicks, they cannot be overworked. However, I feel the results justify an occasional lapse from traditional treatment and show that at times such gimmicks can actually enhance the therapeutic process.

PSYCHOLOGICAL SCREENING UTILIZING THE GROUP APPROACH

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A group screening technique was developed in an attempt to overcome a lack of staff time adequately to interview and evaluate 12 to 18 new patients per week on an active admissions and treatment ward. Previously, individual screening interviews were held by staff persons to determine each new patient's (1) suitability as a psychotherapy candidate; (2) his ability to handle privileges; and (3) his need for further psychological evaluation. In addition to inadequate staff time, there was the problem of overcoming a "set" for individual therapeutic sessions.

It was felt that under group conditions each patient's verbal output could be more easily controlled through the therapist focusing on other group members when a patient's dynamics were obvious or when his delusions and complaints became repetitious. By limiting the group size to six persons and the time to approximately one hour, all new admissions could be seen in three hours, while formerly a maximum of three patients per hour could be seen. A better "cold" evaluation of each patient's behavior could be achieved by adding the factor of interpersonal interactions and reactions to the therapist's observations.

Goals in the screening group were limited. They were: to answer the questions of a patient's suitability for psychotherapy, ability to handle privileges, and need for additional evaluation. This was accomplished through having patients present behavioral incidents related to their deviant behavior. The therapist then could gauge their emotional response patterns and their avoidance and denial of problem areas.

In screening, the therapist took a much more active and direct approach than in group psychotherapy. This approach was utilized to circumvent the individual's defenses quickly and to keep him off balance in order to avoid getting stereotyped reactions and pat answers. After asking each patient to give his ideas regarding why he was in the hospital and limiting his free response to several minutes, the therapist then attempted to foster interaction between group members by drawing out opinions and feelings of each other's problems. With the accelerated pace mentioned and the controlled depth of investigation of each patient's problems, the therapist was able to arrive at conclusions on planning for each patient rapidly. Patients who raised some doubt in the mind of the therapist were referred for further evaluation through psychological testing.

Assignment was made to group psychotherapy on the basis of a pa-

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tient's response to group screening. Those criteria which can be observed in group sessions and have been considered positive signs for good response to group therapy are: (1) the history of the illness being in an acute phase rather than a chronic one; (2) evidence of some higher level of adjustment in the past; (3) above-average intelligence; (4) high energy level; (5) psychologically centered problems as opposed to somatic problems; (6) internal conflict rather than situational problems; and (7) age, which in general tends to favor the response of the younger person to group therapy. Patients were then selected for group psychotherapy on the basis of these criteria as openings in groups occurred.

After four months of utilizing this approach the following advantages to the group screening method (as opposed to individual screening) proved to be:

1. The elimination of a two- to three-week backlog of screening interviews. Every admitted patient is seen promptly by the psychologist.
2. Avoidance of unnecessary diagnostic work on the part of the psychology staff, as the screening report eliminates the need for certain diagnostic instruments and pinpoints problem areas.
3. Patients are seen while their illness is in the acute phase (before they have developed new defenses or stabilized to the hospital setting).
4. Reports are provided to other staff members immediately rather than following the lengthy delays generally experienced under the former system.
5. The screening interviews provide a larger pool of patients to draw from for group psychotherapy.

A NOTE ON THE GROUP MANAGEMENT OF A DISGRUNTLED, SUICIDAL PATIENT

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A 43-year-old, white male came to a VA clinic early in 1962 complaining of headaches, nervous tension, and difficulty in sleeping. The veteran was reluctant to accept treatment from the clinic and requested instead that payment be authorized for his returning to treatment with the private psychiatrist he had previously been seeing. The veteran mentioned having had suicidal thoughts intermittently since his adolescence, and the private psychiatrist telephoned the clinic to inform us that unless the veteran returned to treatment with him, he would undoubtedly carry out his suicidal threat. Concurrently, we received a letter of inquiry concerning our handling of the patient from a prominent U.S. Senator. The VA supervisors supported the position of the clinic, namely, that when appropriate psychiatric care was available in the clinic, private psychiatric care would not be authorized.

In view of our experience that treatment in a permissive group is often helpful to patients with problems in relation to authority, we referred the patient to group psychotherapy. This referral was made despite the patient's repeated objections that his private psychiatrist was of the opinion that group therapy would not help him. The patient was assigned to an open-end group composed of psychotic and sociopathic personality disturbances. The permissive nature of this group was of key importance in the improvement the veteran evidenced and has since maintained. There was little stress on authoritarianism. Members of the group were not questioned when they missed sessions. The leaders were flexible enough, not only to avoid stressing their leadership role, but to permit the patients to "take over" when this was indicated. The patients were very aware of this laissez-faire structure of the group and made frequent comments about it.

The patient played a dominant role in the group sessions, constantly talking in a compulsive manner and seldom appearing to listen to anyone else. He continued to ask for his private psychiatrist, but he consistently attended group psychotherapy three times a week and kept his individual therapy appointment once a week. In general, anything said by a peer was better accepted and better understood than the confrontations and interpretations made by the psychiatrists, and eventually he became friendlier

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with a number of the patients in the group, fraternizing with them over beer after the group therapy sessions.

When one patient began to vie with another group member for patient leadership, this was pointed out to him by the group therapist. It was a competition that existed outside the group as well as within it. For example, the other patient-leader took advantage of the patient and had him pay for most of the beers, to which the patient retaliated by making a very handsome profit on a sleeping bag he sold the other man.

A critical incident occurred when the patient visited the other patient-leader at his apartment and met his wife. The patient asked the wife to dinner in her husband's presence. When the husband suggested that the patient take both of them to dinner, the disgruntled patient complained that he did not have sufficient money. When the wife suggested that he go out on a double date with them and take the wife's girl friend, the patient refused. It was at this point that the married patient remarked, "He doesn't want a girl friend. He wants his mommy."

The disgruntled patient became angry, left the apartment, and began to brood over the incident. At the next group therapy session, he complained, "This man was very unfair to me. He hit me below the belt." He felt the other patient was taking advantage of material that he had learned in the group and was utilizing it against the patient on the outside. When the other patient returned to the group after an absence of a few sessions, both expressed their anger. There was even talk of going outside to "settle the argument."

At the following group session the disgruntled patient told about having had a dream in which he saw his mother floating away from him on the ocean waves. He made no attempt to rescue her. "Now," he said to the group, "I feel that I can give up my mother." He also said that he now felt differently toward the clinic and that he had been foolish to write his senator. He told of how much group therapy had helped him and remarked that combined individual and group psychotherapy was of more help than individual psychotherapy alone. His progress since that time has been excellent.

Ziferstein and Grotjahn (1957) have pointed out that the group therapeutic process may stimulate acting out by mobilizing repressed impulses and loosening defenses and that acting out is more common in group therapy because it may be triggered by the unconscious impulses and anxieties of other patients. In the case presented, the group was used in the interpretation of the acting-out. This appeared to result in the recovery of therapeutically useful memories, associations, and insight in that the patient's acting out ceased after the interpretation ("He wants his mommy") by a

fellow group member.

A note on this case appeared worthwhile because it illustrates the usefulness of a rather loosely organized group in the treatment of a case which presented considerable administrative difficulties and a poor prognosis. In our opinion, the group was an invaluable aid in both the administrative and therapeutic management of this patient.

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THE GROUP PSYCHOTHERAPY LITERATURE 1962

Summarized by

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assisted by

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THEORY

In the seventh paper in the series "A Systematic Theory of Group Psychotherapy," Slavson (114) catalogues and delineates the personality qualifications essential to the group psychotherapist. Noting that the emotional attributes of the therapist are crucial to the dynamics of identification transference, Slavson states that, "Ideas can be taught, but character must be demonstrated. If there is defective ego functioning, instability, confusions, defenses, excitability or emotionality on the part of the therapist, this prevents the formation of strengthened egos in his patients and at the same time increases their anxieties." Other personality requisites described are: poise and judgment, intuition and perceptiveness, empathy (as distinguished from sympathy), imaginativeness, a desire to help others, allotropy and frustration tolerance. In discussing the group therapist's need for insulation against negative feeling, the author indicates, "This state of emotional relaxation is reinforced by a therapist who accepts what seems to be an indisputable fact, that where there is no hostility, there is no therapy."

The April 1962 issue of *This Journal* carries a symposium on Group Treatment Approaches to the Family in which four pertinent papers are offered:

Handlon and Parloff (67) address the question as to whether the treatment of the family group is group psychotherapy. The authors juxtapose the situational realities of the family therapy group against some basic conditions of conventional group therapy. Obvious similarities and differences emerge and the writers indicate the need for research so as to render predictable judgments concerning the therapeutic efficacy of this new and complex technique.

Group psychotherapy of marital couples is appraised in papers by van Emde Boas (129) and Leichter (83). The former describes the emotional re-education which the two sexes achieve in becoming sensitized to their needs and those of their spouses and in the attainment of the capacity for the appropriate expression of aggression. Leichter highlights the auxiliary

¹ Jewish Board of Guardians.

ego function which the spouse performs, "expanding the mate's ego capacity to deal with conflictual material." The decrease of the pathologically symbiotic tie in some marriages is also illustrated.

Jackson (77) offers the symposium's fourth contribution to the study of group approaches to the family with a description of a technique for resolving impasse based upon the pervasive influence of the marital neurosis. The introduction of the primary patient's spouse into the individual psychotherapeutic session produced an immediate activation of the treatment.

The advantages derived from the family interview in the formulation of dynamic diagnosis are presented by Davanzo (39). In addition to making observable the principal pathogenic data, the method is seen as encouraging the positive collaboration of other family members in the patient's treatment.

The use of family casework interviews to deepen the diagnostic understanding of a family's "life style" is discussed by Weiss (133), who notes that it is often possible to observe behavioral responses during a family interview that are not available for conscious verbalization by the client. Faucett (51) discusses the resistances among caseworkers to involving themselves in leading family treatment sessions, and emphasizes through a case presentation the value of therapeutic intervention through family interviewing at the height of a family crisis. Scherz (110) defines the indications and contraindications for family casework interviewing, and discusses some technical considerations in leading group interviews.

The need for further theoretical and clinical work in developing family treatment techniques is stressed by Arnold (6) who contends that the sociological concept of "triadic turmoil," i.e., the apparently inherent tendency of a three person group to subdivide into a pair of allies and an outsider, is pertinent both to the relationship patterns within families and to the individual treatment relationship between one family member and a therapist, which excludes other family members.

The relevance and application of social science concepts and small-group theory to the treatment of the family as a group is discussed by Coyle (34).

Recent theoretical and clinical advances in family group therapy are discussed by Bell (14).

In a theoretical presentation, Mann (86) offers a psychoanalytic appraisal of conformity in groups. He finds it to be most frequently neurotically based and emphasizes conforming reactions arising from a dependent-hostile identification with the leader. The author suggests that, "Conformity remains an illusion and an expression of opportunism so long as, with some

exceptions, people as individuals or in groups have an abiding need to maintain the priority of their own infantile needs."

Stock (119) identifies interpersonal concerns and specific anxieties which arise in early sessions of therapy groups and examines the processes involved in their emergence and exploration. It is noted that the group situation elicits expectations of rejection, criticism, and ridicule. These concerns are initially expressed in indirect ways, i.e., via displacement of the affect or object. As reality testing continues and trust develops, these anxieties are permitted more direct expression.

The early aspects of group life are also studied by Geller (59), who charts characteristic stages of development: uncertainty, overaggression, regression, and then gradual accommodation. The parataxic distortions employed at each level are delineated.

Stock and Lieberman (120) describe the issues, considerations, successes, and failures involved in an effort to develop appropriate procedures for assessing total group phenomena in group therapy.

The relationship between residual parental threat and selective interaction in group therapy is studied by Berzon (16).

In a critique of the group therapy literature, Slavson (116) observes that it reflects existing confusions in individual psychotherapy. The appearance in the literature of unsupported hypotheses and of doctrines and practices of "somewhat bizarre character" is deplored. An urgent need is seen for controlled and valid research to ascertain effectiveness with specific patients as to age, sex, and clinical categories.

In a synthesis of Freud's concepts of libidinal and aggressive instincts with their own empirical observations, Arsenian, Semrad, and Shapiro (8) postulate cohesion and dispersion as integral functions in small groups. Cohesive and disruptive forces are identified and the task of the leader in absorbing and neutralizing the excess of aggressive energy is emphasized. Implications of this conceptual duality for training groups are drawn.

Glatzer (62) sees group treatment as a therapeutic facility through which the therapist is helped to make effective inroads into the "tenacious oral resistances" of narcissistic patients. In the group, deeply repressed masochistic transferences are subject to repeated illustration, peer observation, and analysis.

In an overview of group psychotherapy Berger (15) examines past, present, and future developments, relation to the community at large, issues currently confronting the field, and the responsibilities of group therapists in strengthening our Association, extending training, and enhancing societal mental health.

In a twenty-year retrospectus of group psychotherapy, Rome (104)

casts an objective eye upon its development, achievements, inadequacies, and confusions. The weakness of group therapy research is noted with its substitution of description, anecdote, and clinical observation for methodological rigor.

In considering various aspects of the individual's treatment within an analytic group, Foulkes (55) discusses at length the development and working out of multiple transference reactions which arise during the group treatment. He develops the theory that each patient's neurotic disturbance is played out among a circle of intimately involved people, including family members, friends, and, at times, the therapists treating various people in this circle. These people tend to act out different aspects of the neurosis and, according to Foulkes, should ideally be treated together in one therapeutic group.

The nature of transference reactions in group therapy, how and why they occur and the differences between their occurrence in group as compared with individual treatment, are discussed by Farrell (50). He contends that the understanding and resolution of these multiple transference phenomena is the fundamental cause of therapeutic change in group psychotherapy.

Gans (58) evaluates the utility and desirability of the use of co-therapists as a therapeutic instrument. The method is viewed as advantageous in training and in certain group situations in which greater distribution of authority is needed; in other group situations "the currents of co-therapist strife" may negate its use.

The use of more than one leader during group therapy meetings is also discussed by Block (21) as a therapeutic and teaching tool.

Papers by De Rosis (42) and Becker (12) discuss the concepts of alienation and self-alienation and illustrate the use of group analytic procedures in overcoming separation from self and others.

The development of a therapeutic community in a general hospital is traced by Johnson (78), who notes the significant resemblance to societal living in the mutual responsibilities within the program of personnel and patients. The program is also seen as a valuable training ground for resident staff and nursing personnel.

A summary review of current practice, based on a questionnaire submitted to ninety-two group therapists, is presented by Rosenbaum and Hartley (105) and offers a cross-section of opinion on grouping and selection patterns, optimal size of groups, and perceived indications and contraindications for group psychotherapy.

A posthumous paper by Hulse (74) illustrates the therapist's activity in effecting a "dynamically charged and therapeutically pregnant" group session through the method of "communalization" (universalization).

The contribution of visual observation to the understanding of treatment sessions and a methodological approach to the study of visual communication are presented by Daniels and Prosen (37). Eye and face movements are discussed by Winick and Holt (136) as motoric communications of feelings that are not readily verbalized in the group meetings.

The group psychotherapy literature for 1961, covering 155 papers in English and other languages is reviewed in this Journal by Rosenthal and Schamess (108); and in another publication by Daniels, McFarland, and Solon (38).

A content analysis of the interactions within a counseling group of gifted, underachieving adolescents is presented by Wigel and Ohlsen (135).

Moreno (91) proposes that the term "socioanalytic group psychotherapy" be used to differentiate group psychotherapy based on sociometric principles from psychoanalytically oriented group psychotherapy. He deplores the introduction of psychoanalytic theory into group practice and contends that "socioanalysis" will become the dominant therapeutic method of future times.

The evolution of group therapy procedure within the Adlerian School of Individual Psychology is reviewed by Adler (1), who discusses both the development of concepts and the work of practitioners.

In reviewing his experiences and findings while leading biweekly classroom discussions with student nurses concerning problems arising during their professional training, Gladstone (61) notes that it was possible to understand and work through aspects of socially shared pathology around such issues as relationship to authority, identity problems, and passivity, without threatening individual integrity.

Lindt and Pennal (84) examine some of the defensive uses made of group membership in our society and suggest a trio of life situations in which the individual needs the protection of a group in order to maintain his functioning: (1) amidst strong separation anxiety, (2) in quest of identity, (3) an impasse in the life of the individual.

A descriptive account of the introduction of a therapeutic community approach in a center for the treatment of neurosis is rendered by Crockett (35). The crucial clinical-administrative step is seen as changing the authority structure from vertical to horizontal levels for the facilitation of maximum communication.

In a research effort the methodology for analysis of the content of a group protocol is formulated by Rosenberg (106), who uses contiguity as a basis for statistical analysis.

Lakin and Dobbs (80) offer a process analysis of a group session and

suggest the application of group dynamics research and theoretical tools to effect greater understanding of group therapeutic problems.

The use of combined individual and group psychotherapy with separate therapists is seen by Teicher (126) as a valuable technique when utilized to demonstrate to patients the nature of their behavior and the conscious and unconscious use they make of conflicting loyalties.

Sabath (109) examines several aspects of transference relations among members of the psychotherapeutic team and notes that therapists, as well as patients, derived personal benefit from experience with group therapy.

Material from two groups is presented by Belinkoff, et al. (13) to illustrate reactions to a change in therapists. The range of feeling, from immediate hostile resistance through symptom development, themes relating to separation, and finally to identification with the new therapist is discussed.

A study by Derr and Silver (43) of prediction based on test protocols, concerning the participation and behavior of patients in group therapy, did not offer convincing evidence of the clinicians' ability to make accurate predictions.

Rickard (102) reviews and evaluates twenty-two experimental studies in which at least one control group and one objective measure of change were used to determine the effectiveness of group psychotherapy. He points out problem areas in these studies and suggests possibilities for future research projects.

No clear-cut relationship was found between patient improvement and the amount of verbalization, the topics discussed or the affect connected with these topics, in a study of five counselling groups by Ohlsen and Oelke (95).

An unpleasant auditory stimulus introduced into a continuing psychotherapy group during periods of silence is reported by Heckel, Wiggins, and Salzberg (70) to have reduced both the number and duration of these periods.

An experiment in which written instructions discussing the purpose, setting, and process of group treatment were given to members of a psychotherapeutic group by the therapist is reported by Martin and Shewmaker (87), who conclude that these instructions became a useful aid in overcoming neurotic defenses.

The impact of the group leader's death on the psychotherapist members of a training group in analytic group therapy is reported by Aronson, Furst, Krasner, and Liff (7). They discuss this group's inability to complete a research study concerning their reactions to the leader's death.

The importance of meeting the emotional and human needs of people in training as psychodramatists and group therapists is stressed by Stein (118) in his discussion of group training meetings.

NONPSYCHOTIC ADULTS

Principles, procedures, and techniques in group psychotherapy with alcoholics are presented by Fox (56), who notes that "so helpful is group therapy to the alcoholic, that it should be instituted as soon as possible, often on the very day of the first contact. . . ."

An experimental program in which hospitalized alcoholic patients were formed into a modified therapeutic community with increased responsibility for self-government and were then involved in therapeutic groups, each one led by a different member of the ward staff, is discussed by Olsen (96), who reports that this treatment program led to a reduction in authoritarianism and a greater understanding of patient problems by staff members at all levels of responsibility.

A form of treatment for alcoholics, providing short-term hospitalization followed by prolonged outpatient group psychotherapy, is described by Walton (130), who discusses how the group members develop the realization that drinking stems from inner stresses that can be modified with help, after an initial period of resocialization and identification with each other. Strayer (121) discusses his experience in leading a therapeutic group for alcoholic male outpatients, in which most members remained in group treatment between five and eight years. He notes that the main impetus for therapeutic change seemed to develop from the group members' realization that they still experienced the same tensions that had originally provoked uncontrollable drinking episodes, even after long periods of abstinence.

A method of deciphering the "special language" of alcoholics is suggested by Esser (48), who structures his group meetings with outpatient alcoholics so that the entire discussion revolves around and is limited to responses to one question raised by the therapist. The discussion is recorded and then played back to the group for further reactions and clarification.

Brief group psychotherapy of six compulsory one and one-half hour meetings was not found to have had any significant effect on the attitudes of hospitalized narcotic addicts, according to a study by Blachly, Pepper, Scott, and Baganz (19).

A study by Cabeen and Coleman (30) negates some of the commonly accepted criteria relating to the amenability of sex offenders to group psychotherapy. It was thus found that older patients, those whose offenses involved homosexual offenses, repeaters, and those of lower intelligence (excluding mental deficiency) were not necessarily poorer treatment risks than younger patients, heterosexual offenders, first offenders, and those of higher intelligence.

In a study conducted with adult probationers, Bassin and Smith (10)

found no significant relationship between the amount of talking in group therapy and the extent of change.

An open-ended group developed to screen, orient, and motivate V.A. outpatients for psychotherapy is reported by Dibner, Palmer, and Cohen (44).

Group psychotherapy is seen by Uehling (128) as offering an effective arena in which the criminal offender's defensive repression of affective areas can be dealt with. The necessity for bridging the gulf between the institution's disciplinary function and the individual's basic needs is pointed out.

The integration of concurrent individual and group psychotherapy in the treatment of a hysterical personality is the subject of a case report by Papanek (99). In the group the patient, a highly dependent person, began to experience herself as a separate identity and learned to relate to others without absorbing or being absorbed by them. Individual sessions were essential for partial gratification of intense security needs and for helping the patient understand and assimilate the new experiences encountered in the group.

In reporting their experience with marital group psychotherapy, Flint and MacLennan (54) offer clinical observation of the effect of the spouse's presence upon group dynamics, transference, resistance, and outcome. Criteria for selection for this modality are also presented.

The treatment of neurotic young adults in groups for married couples is discussed by Henker (71) from both a theoretical and a clinical point of view.

In a report on the use of group psychotherapy in the training of students of marriage counseling and family life education in a university setting, Ormont (97) illustrates that "the group experience can be an engrossing adventure in self-discovery as well as a giant stride toward professional competence."

The use of therapist-led social groups as an adjunct to psychotherapy is described by Fleischl (53) as a method of helping patients increase social interaction and overcome detachment in social situations.

Group therapy is suggested by Bucher (28) as a method of consolidating and extending gains made in individual treatment, after individual treatment has been terminated.

A pilot project in which families that had been delinquent in their rent payments to the N.Y.C. Housing Authority were invited to participate in a group education institute is reported by Rogers (103), who notes that many of the families attending these meetings developed more mature and responsible attitudes toward meeting their obligations as tenants and as family members, after initial suspiciousness and resentment toward authority had been expressed in the meetings and handled by the group leader.

Short-term group treatment of adults with phobic disorders, using the technique of systematic desensitization (reconditioning), is reported by Lazarus (82), whose findings indicate that this method of treatment was more successful in quickly alleviating phobic symptoms than was traditional interpretive group psychotherapy of the same duration.

Guidance groups as a means of involving passive, resistive, and previously inaccessible fathers in family treatment are discussed by Strean (123).

Strean (122) also examines the therapeutic factors and strategy involved in the introduction of a new member in group psychotherapy, suggesting that the therapist "should assume the role of the parent who decides when the family is ready for the newcomer."

Problems of technique in group psychotherapy with fathers are dealt with by Grunebaum (65), who addresses problems of forming a group when the members do not come for therapy for themselves and of the defensive hostility mobilized by the threat of closeness.

Aspects of transference and countertransference in group counselling with parolees and in the interaction of group leaders with the consultant are depicted by Illing (75).

A successful analytic group psychotherapeutic experience with parents of psychotic children is described by Munzer (92). Careful consideration of the special strengths and vulnerable areas of this closed group led to appropriate modifications of the therapist's role, which facilitated and enhanced therapeutic progress.

Group therapy with the parents of children in individual treatment is recommended by Hampton (66) as an effective means of reducing parental resistance, reinforcing self-examination, and involving the parents in non-familial transference relationships which reduce their irrational, unconscious demands on their children.

In his study of group therapy sessions with the parents of hospitalized, male adolescent drug addicts, Hirsch (73) emphasizes the causal role of the mother's unhappiness in her marriage and her need to produce a passive, masochistic son, identified with her father rather than with the child's father. Group treatment is difficult with these parents because of their unconscious need to destroy their children, and their overwhelming guilt, but further exploration of group methods is recommended.

A short-term group therapy program for the mothers of mentally retarded children is reported by Cummings and Stock (36), who emphasize the value of allowing these mothers to ventilate intense feelings of anger, disappointment, and self-recrimination; obtain constructive advice; and evaluate whether they need longer, more intensive treatment.

Certain sequential therapeutic dynamics operative in mothers' groups

are defined operationally and clinically illustrated by Andrews (3) and presented as: (1) group balance, (2) group task orientation, (3) universalization, (4) extensive emotional support, (5) extensive defense confrontation, and (6) experiential validation.

A three-year experiment in peer group "coffee-house supervision" is described by Shatan, Brody, and Ghent (112) as a "unique experience of the deepest intimacy." In a procedure which established itself somewhere between classical supervision and group analysis, the participants emotionally perceived the "massive importance of countertransference in those aspects of therapeutic technique which are not learned in the usual sense but which spring from the strengths and limitations of the therapist's personality."

Eaton (46) discusses dynamics, implications, and effects of sexual acting out in members of the same therapy group with special reference to the role of pregenital conflicts. Techniques are cited for handling potential acting-out behavior through active anticipatory interpretive analytic efforts and early work on pregenital defenses.

An evaluation of the value of overtly expressed hostility in the psychotherapy group is rendered by Papanek (98), who states, "Anger expressed in the group is therapeutic and constructive if it results in a learning experience and contributes to the strengthening of the patients' social feeling."

Inability to release intense pent-up rage toward a spouse during group therapy sessions and the patient's perception that other group members disapprove of him for having these feelings are suggested by McCartney (88) as causal factors in the suicides of two patients who had been in combined group and individual treatment.

The effective use of group analytic procedures with adult stutterers is presented by Barbara, Goldart, and Oram (9), who offer a theoretical discussion of the onset of stuttering and describe the significance of the group as a valid reality-testing experience in an atmosphere of union and unity.

The methods by which administrative staff resistance to the establishment of a social work group therapy program in a general hospital was overcome is discussed by Apaka and Sanges (5), who also present case material illustrating how the group treatment of ten arteriosclerotic patients on a geriatric ward helped to reduce social isolation and withdrawal and strengthened these patients in their desire to remain alive and enjoy life.

In her report on group counselling with medical outpatients between the ages of sixty and seventy-five, Allen (2) notes that it was necessary for these patients to develop and partially resolve a strong transference toward the leader as "mother" before they could become actively involved in relationships with each other.

A program combining medical care, group psychotherapy, and recreational therapy for forty-five elderly male patients suffering from general medical problems is evaluated by Deaton, Lair, and Smith (41), who conclude that a relatively long period of rehabilitation therapy tended to reduce the rate of return to the hospital after discharge.

Murray (93) reports on the treatment of malunion of the femur through group therapy and psychodrama.

In surveying his experience as a group therapist with adult offenders, Ionedes (76) emphasizes that hostility and resentment toward society prevent the offender from attempting any self-examination until the therapist has won his respect and friendship. This task is facilitated in group treatment because the offender is not alone in the group and is therefore better able to face the therapist, who at first represents society to him. The social structure of a prison and the nature of the inmate culture are carefully discussed by Taylor (125) in his report on the development of group themes and the resistances to treatment among members of a therapy group in a New Zealand prison.

An experimental study of group psychotherapy with nearly inarticulate, mentally defective young adults is discussed by Tavris (124) in an effort to evaluate whether personality change can take place in these very limited patients whose capacity to understand interpretations and to develop insight is almost nonexistent.

In reviewing his ten years of experience in treating women in psychotherapeutic groups, Gray (64) concludes that analytically oriented group guidance can be successfully concluded in approximately one year of weekly meetings.

In his case presentation of the combined group and individual treatment of a sociopathic young man, Beacher (11) discusses in detail how the patient established and worked through multiple transference relationships, and how the analysis of these transferences brought about a marked change in his personality structure.

PSYCHOTIC ADULTS

O'Hearne (94) offers techniques and a confident rationale for dealing with actively delusional patients in group psychotherapy.

In an investigation of subgroup and inter-subgroup relationships on a closed ward in a state hospital, Chen (31) found that the geographical locations chosen by groups reflected their members' clinical pictures. The shifting of a patient's location from one area to another frequently represented "upward mobility" toward healthier subgroups.

The historical development of social clubs in England, their structure,

program, and usefulness in helping chronic psychiatric patients function better and develop relationships, are described by Bierer (18). In a second article, Bierer (17) emphasizes the importance of therapy groups, social groups, and group meetings directed toward the development of "guided self-government" in developing effective day-hospital programs.

The history, development, and theoretical basis of family psychotherapy is reviewed by Gralnick (63) in discussing how he became involved in doing family psychotherapy with hospitalized borderline and psychotic patients. He concludes that family meetings offer a unique method of deepening our understanding of psychopathology and of treating patients with whom more traditional forms of psychotherapy have proved unrewarding. Rabiner, Molinski, and Gralnick (101) contend that individual psychotherapy is not effective with hospitalized schizophrenic patients because of the schizophrenic's tendency toward withdrawal and his compulsory dependence on his family with whom he lives in an atmosphere of mutual misunderstanding and recrimination. Conjoint family treatment is, they contend, an effective way of altering some of the family patterns that contribute to the patient's recurring pattern of self-defeat. They also note that this form of treatment may promote countertransference problems since the therapist tends to see himself as the sole judge and arbiter for the entire family.

Criteria of group selection and the extensive use of didactic methods are emphasized by Boenheim and Dillon (22) in their report on therapy groups in a mental hospital.

A program of weekly meetings between the staff and patients at a hospital for the rehabilitation of chronic schizophrenic patients is discussed by Deane (40) as having been helpful in promoting communication and more democratic relationships between staff and patients.

Various group and sociometric techniques by which occupational therapy sessions in a psychiatric hospital can be structured as group therapy meetings are discussed by Lapp (81).

A program in which group therapy is used with hospitalized psychiatric patients and with selected groups of working outpatients, to help them make use of vocational training and maintain jobs in the community, is discussed by McDaniel (89), who emphasizes that inability to work after release from a mental hospital is most frequently the result of inadequate social skills.

A group therapy program designed to increase intellectual stimulation among hospitalized schizophrenic patients, is described by Friedman (57).

An experimental study comparing the effectiveness of group psychotherapy and a specially designed activity program in the treatment of

chronic hospitalized schizophrenic patients is reported by Anker and Walsh (4) whose findings show that the activity program produced significant and consistent positive changes according to the MACC Behavioral Adjustment Scale, while the therapy group did not.

An experimental attempt to increase the amount of subject-to-subject speech and decrease the amount of subject-to-experimenter speech in a group therapy-like situation is reported by Hannon, Battle, and Adams (68).

A program in which psychiatric nurses lead therapy groups with hospitalized psychotic patients is reported by Brown (27). Clack and Wackerman (32) discuss the development and resolution of intense rivalry between two patients in a therapy group for hospitalized psychotic patients, led by psychiatric nurses.

A program of milieu therapy for hospitalized psychiatric patients including daily ward meetings between the patients and hospital staff to discuss hospital policy and increase patient participation in community life is described by Mako, Crawfis, and Peer (85).

CHILDREN

In further observations on group therapy with adolescent delinquent boys in residential treatment, Epstein and Slavson (47) and Slavson (115) offer significant contributions to therapy and practice in this area. The first paper deals with "breakthrough" in the treatment of a group of markedly resistive delinquent boys achieved through conversion of projection into self-confrontation and self-examination. In addition to the dramatic handling of the resistance, the development of the group and its therapeutic phases are depicted. The second paper, a case study, highlights the enactment of a transference neurosis by an adolescent boy who transferred upon the group therapist his homosexual tie to an older brother. While the patient's group treatment effected positive results in ego areas of self-image and personality integration, these partial modifications could not be sustained under the inordinately stressful life situation which he encountered at home after discharge from the institution.

The successful treatment of a markedly stigmatized boy in activity group therapy is recorded and appraised by Scheidlinger, Eisenberg, King, and Ostrower (111). On the basis of positive therapeutic results achieved in the face of neurological damage, physical stigmata, and serious psychosocial dislocation, the potential inherent in the use of activity group therapy with selected, severely damaged children is underscored.

A study by Feder (52) supports the contention that short-term discus-

sion group therapy promotes therapeutic readiness in institutionalized adolescent delinquent boys.

In a brief communication, Karmiol (79) offers observations on combined individual and group psychotherapy of adolescents.

In his report on group psychotherapy with institutionalized delinquent, adolescent girls, Hersko (72) discusses the particular difficulties involved in the group treatment of adolescents from the point of view of transference, countertransference, resistance, anxiety levels, and the therapist's role. He emphasizes the importance of using ego-building techniques to help adolescents achieve a more stable sense of identity.

Group therapy sessions with institutionalized delinquent adolescents, using sociodrama and discussion techniques, were found by Head (69) to be helpful in changing attitudes, improving social relationships, and developing insights into behavior problems.

An experimental program in which children in foster home placements were involved in a group therapy program where both discussion and role playing techniques were used is described by McManus (90).

A program of child-centered guidance groups for adoptive parents is presented by Conklin, Vielbig, and Blakely (33), who report that the parents became more secure in their relationships with the children and better able to verbalize their negative feelings. The placement agency was helped to evaluate more objectively the success of their adoptive placements and to offer individual counselling where needed.

A project in which eight adolescent children whose symptomatology included frequent absenteeism from school, recurrent psychosomatic complaints, and academic underachievement were treated in a coed group in a public school setting is reported by Westendorp, Abramson, and Wirt (134), who freely discuss the nature of their difficulties in establishing and working with this group.

A program for the psychoanalytic group treatment of school-age children and their parents is outlined by Boulanger (23), who discusses the need for improved psychiatric services for children and the usefulness of both group therapy and psychodramatic techniques.

The use of family group interviewing by a three discipline team in the intake process of a child guidance clinic is discussed by Tyler, Truunmaa, and Henshaw (127), who note that this method deepens the understanding of family interaction and facilitates treatment planning for the child.

Group discussions are one aspect of a pre-admission program for parents at a hospital for mentally retarded infants and children under seven described by Probststein and Kusuda (100).

OTHER LANGUAGE REPORTS

Reports on group psychotherapy in other languages were received from France, Belgium, Italy, Germany, Switzerland, Sweden, Norway, and Czechoslovakia.

Rosenburg (107) describes group therapy with delinquents; Weisenhutter (132) finds group treatment methods to be most suitable for youth in the experience of a German psychotherapeutic education centre. Weidemann (131) portrays the social behavior characteristics of the sick child.

Esser (49) and Sjostrom (113) present group psychotherapeutic modalities with alcoholics.

The importance of cultural patterns in group psychotherapy is emphasized by Bustamente (29); Spaltro (117) correlates the group and group psychotherapy. The beginnings of a therapeutic group are traced by Zimmerman (138). Zimmerman (137) delineates characteristic features of dreams in analytic groups. Genevard (60) and his co-workers discuss group psychotherapy's contribution to the understanding of neurosis.

Reports on group psychotherapeutic practices in mental hospitals are rendered by Bratfos and Sagedal (26), Brack (25), Dolezal and Hausner (45), Bour (24) and Bloch (20).

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BOOK REVIEWS

Edited by BERYCE W. MacLENNAN, Ph.D.

IDENTITY. MENTAL HEALTH AND VALUE SYSTEM. CROSS-CULTURAL STUDIES IN MENTAL HEALTH. Edited by *Kenneth Soddy*. Chicago: Quadrangle Books, 1962, 271 pp., \$6.75.

A World Mental Health Year Publication, this cooperatively produced contribution by a top-flight scientific committee includes the consensus of the group as well as individual points of view which are clearly labeled by variations in margins. An excellent job of editing has been done by Dr. Soddy. The World Federation for Mental Health justified the choice of topics on the basis that any social action which they might undertake to improve the mental health of populations must be based on the most adequate conceptual foundations that can be laid.

Identity as a concept about individuals and groups was found to be the most prevalent topic in discussions held by the WFMH. Covered in this report are the reciprocal nature of the concept of identity "as an anchorage of the self in the social matrix," of identity as a continuum, and as related to the concepts of "ego, self, identification, individuation, empathy, identity, persona, person, character, temperament, empathy, identity strength, and ego strength." Cultural factors and identity are reviewed in relation to social role, status, class, peer culture phenomena, and nationalism.

The continuity, coherence, and flexibility of identity are described as basic to adequate integration of individual personality and to the stability of group formation. Identities may be multiple and exist in varying hierarchies and styles depending on location in time and place, and they may be modified by internal and external stresses and strains.

The largest portion of the book is devoted to a section on "Mental Health and Value Systems" which inquires into the compatibility of contemporary mental health concepts and various religions and ideologies. The major contribution of this study lies in testing out the meaning of mental health concepts in different ideological and cultural milieus. It was assumed that the prevailing religion or ideology of a community was in many senses an expression and source of its value system. It was agreed that the aim should be to export mental health concepts in a way that would help people find their own direction toward goals of their own conception.

The great religions and ideologies seem to demonstrate four common areas of agreement in connection with the pursuit of health: the value of intellectual study; the renunciation of the things of the flesh; devotion in order to understand the mysteries; and the pursuit of health through action.

Practical implications arising from the study included the need for awareness of the effect on individuals of sudden changes in family patterns and of the conditions needed for readiness for change. The volume notes that when central values of an individual or community are threatened, anxiety and insecurity may increase to a harmful degree. Cultural influences may affect the capacity to perceive and move toward aspirations. The mental health worker needs to have cultural understanding but not necessarily cultural identification.

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APPLICATION OF PSYCHIATRIC INSIGHTS TO CROSS-CULTURAL COMMUNICATION. By the Group for the Advancement of Psychiatry. New York, 1961, 55 pp., \$.75 (paperbound).

The distinguished group who took part in this symposium on the application of psychiatric insights to cross-cultural communication included psychiatrists, a sociologist, and an anthropologist, all of whom have had experience in work with the other disciplines. The fact that such a symposium was planned and persons from these varied backgrounds contributed to a common topic gives encouragement to all who want to see cross-disciplinary work done in cross-cultural fields.

In a discussion of international communication, Dr. Wedge states that "every psychiatric interview aims at understanding and communicating with other persons, and may be looked upon as an experiment in trans-cultural communication, since no two persons represent precisely the same cultural experience." While this is so, it does not necessarily follow that this person-to-person experience gives the psychiatrist an adequate basis for developing models and techniques which "can usefully be applied to problems of communication between nations." Others, such as professional diplomats and anthropologists, contribute to the understanding of international communication, and if the psychiatrist is to play the consultant's role in international meetings, he should have the diplomat and social scientist beside him.

The paper by Dr. Ruth Useem has the great virtue of talking about "the contexts of communication." Her insight is well summarized when she states, "Bridges are useless unless there are roads on both sides leading to the bridges." Her paper shows special understanding of the sociological approach to communication. Dr. Bertram Schaffner's caution seems appropriate in this complex field. He points out that we are "just at the begin-

ning of our exploration of the interrelations between rational-technical and the emotional meanings of words and actions in the communicative process, and how these are influenced by the development from childhood through adulthood of culturally patterned maps of average expectable relations."

Dr. William Caudill's reflections on his experiences in Japan contain interesting applications of dynamic psychology to exotic differences between cultures. For example, his idea of attenuated childhood and dependence on the part of the Japanese suggests an interesting hypothesis concerning cultural differences between them and people from the United States. Dr. Caudill would be the first to agree that his observations should be regarded as the beginning of a study rather than its conclusion.

When one leaves the security of his own special field, the complexity of the research problems increases, as does also the need for humility and caution. Nevertheless, the stakes are high and the effort can be rewarding. GAP is to be congratulated on taking an important step in this direction.

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SUICIDE AND MASS SUICIDE. By Joost A. M. Meerloo. New York: Grune and Stratton, 1962, 159 pp., \$3.75.

The author, well-known for his numerous and varied writings, admits in the foreword that he likes the essay form. Indeed, he excels in it, and the present book should be evaluated as a series of essays rather than a scientific, scholarly study. Nevertheless, the easy style and the literary form do not detract from the seriousness of approach and the caliber of constructive thinking which have gone into the nineteen chapters of this provocative study.

Insights derived from psychoanalysis and existential philosophy join hands with reflections on problems facing man in modern society. Throughout his book Meerloo emphasizes the importance of the destructive drive, which, when turned against the self, gives rise to the wish for self-annihilation. The sociological approach makes the author consider at some length the problem of mass suicide which accounts for some of the most gruesome phenomena of group psychopathology in recorded history.

Meerloo claims that the "suicidal man" exists in everybody and is infectious—hence, the taboos and punishments meant to protect the individual and society from an impulse which may easily become contagious. Remarks on the individual psychology and psychopathology of suicide are based on the author's rich clinical experience. The complex motivations for

suicide receive an illuminating presentation. Chapters about passive and psychic suicide, about heroism and the defiance of life and death must be singled out as particularly interesting.

Wealth of personal experience gives the reflections of Meerloo an important touch of substantiality and integrity: the book is interspersed with some moving autobiographical confessions.

A chapter on creativity as a way of overcoming individual death is a liberating allegro in a symphonic poem full of sombre notes.

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EXISTENTIAL PSYCHOLOGY. Edited by *Rollo May*. New York: Random House, 1961, 126 pp., \$.95 (paperbound).

In effect, this splendid little volume is the introduction of existential psychology, known to Europe for over a score of years, to America. Rollo May traces its history, citing Kierkegaard, William James, and Paul Tillich. The key concept is "immediate experiencing" as the basis of reality. The focus is upon the "existing," "becoming," "emerging" human being in the "world at the moment." "Will" and "decision" make the true man. Rollo candidly points up the beneficial and the questionable in this discipline.

A. H. Maslow finds that existentialism may provide psychology with a philosophic foundation, a beginning answer to "what is man?" Psychology needs the concept "that man has the future within him." Herman Feifel explores the fact of death. It is more than a biological event. He argues for research on the meaning of death, an honest grappling with it, because of the significant relationship it has to the individual's philosophy of life.

Rollo May outlines several principles of psychotherapy derived from the existential approach, "ontological characteristics": (1) neurosis is an adjustment, a way of accepting non-being; (2) every existing person has the need to preserve his centeredness; (3) all existing persons have the need and possibility of going out of their centeredness to participate in other human beings; (4) awareness is the subjective side of centeredness; (5) the uniquely human form of awareness is self-consciousness. The task of the therapist is to "transmute awareness into consciousness."

Carl Rogers comments on the objective and existential trends, finding them complementary rather than contradictory. Gordon W. Allport distinguishes between "lives in which the existential layer is, in effect, the whole personality, and other lives in which it is a mere mask for the rumblings of the unconscious." Joseph Lyons provides a valuable bibliography to the entire field.

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THE DIVIDED SELF: AN EXISTENTIAL STUDY IN SANITY AND MADNESS. By R. D. Laing. Chicago: Quadrangle Books, 1960, 240 pp., \$5.00.

The Divided Self is an unusually interesting and original study of schizoid and schizophrenic persons by a young English existential psychiatrist. In his basic purpose of making sanity, madness, and the process of going mad comprehensible, Dr. Laing achieves remarkable success. He concentrates on an attempt to characterize the nature of a person's experience of his world and himself and depicts the patient as setting up all particular experiences within the context of his whole being-in-his-world.

The reviewer's initial expectation of obscure, metaphysical language was not realized. On the contrary, this book could hardly be more clinical in its clear style and content. In fact, Dr. Laing seriously objects "to the technical vocabulary currently used to describe psychiatric patients" in which "words are specifically designed to keep the patients at a distance, with isolating concepts and dehumanized circumscribed terminology."

The essence of the author's existential contribution is conveyed in his chapter on "ontological insecurity." With this rather abstract, inelegant phrase, he describes the "pivotal issue" of the patients' lives, commenting that this critical issue is not discovered in the unconscious. The individual with a primary ontological security experiences his own being as real, alive, whole, differentiated so clearly from the rest of the world that his identity and autonomy are never in question. If such a position has not been reached, the ordinary experiences of everyday life constitute a continual and deadly threat. If the sense of personal autonomy has not been achieved, there is both a failure to sustain the sense of one's self as a person with the other and a failure to sustain it alone. Only if this is realized, the author says, is it possible to understand how certain psychoses can develop.

He consistently applies this theme of ontological security and autonomy to the cases he uses for illustration, tracing it through the early life history right up to the therapeutic situation. He describes three aspects of anxiety derived from ontological insecurity. The first is "engulfment," wherein the individual dreads relatedness with anyone or anything because of the uncertainty about the stability of his own autonomy. "Implosion" refers to the anxiety in the individual who feels empty but dreads contact with reality, which threatens his identity based on his very feelings of nothingness. The third form of anxiety involves being petrified or turned to stone. Experiences with others are dreaded as deadening and depersonalizing. Dr. Laing was able to make the phenomenon of depersonalization most vivid for this reader.

In other chapters the author describes patients whose being becomes organized into the basic split between mind and body. In two chapters, "The Embodied and Unembodied Self" and "The Inner Self," he examines the split between true and false self systems. His chapter on "Self Con-

sciousness" is particularly interesting. The final chapters are devoted to psychotic developments and to a study of chronic schizophrenia.

The question of Dr. Laing's therapeutic effectiveness is not dealt with in this book. However, the reviewer certainly gained the impression that the results of his treatment methods seemed hopeful.

This book is recommended for its refreshing originality and because it adds illumination to one of the most baffling and confusing areas challenging society and medicine.

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VALUES IN PSYCHOTHERAPY. By *Charlotte Buhler*. New York: Free Press of Glencoe, 1962, 266 pp., \$5.25.

The issues surrounding values in psychotherapy are vital, timely, and stimulating ones today. As is exemplified by the several surveys quoted in this volume, most dynamic psychotherapists are aware that, like it or not, they convey their own values to the patient by word or act and by what is not said or not done. Dr. Buhler raises the questions of how explicit such communications should be and what might be their therapeutic purpose. Her discussion of the basic tendencies in life which each therapist has and his personal solutions which he communicates as values to his patient is illuminated by her own version of these tendencies and drives. She names four: need satisfaction, self-limiting adaptation, expansive creativity, and upholding of internal order.

In addition to the introductory discussion of the problem of values in psychotherapy, there are chapters on theoretical concepts of values, the self and personality theory, the self and values in human development, values in healthy and neurotic development, the role of values and beliefs in human life, and values in psychotherapy.

I found Dr. Buhler's constant effort to quote many and varied authorities in order to present a many-sided picture rather disconcerting. While the quotations are informative, they make the substance and reasoning in each chapter choppy, irregular, and difficult to follow. Worse, the lengthy quotes are not well integrated with Dr. Buhler's own material. Although I share her enthusiasm for Erikson's work, her extensive use of his writings are at the expense of her own very worthwhile and cogent discussion with which I am familiar and which might have made this a very much more stimulating book. Ekstein's contribution, "Reflection on Parallels in Therapeutic and Social Process," is doubly welcome because of its uninterrupted exposition as well as the fact that it is a scholarly and thoughtful paper.

In general, I regret that this volume did not make the contributions it could have to the problem of values in psychotherapy.

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STUDIES IN BEHAVIOR PATHOLOGY. Edited by *Theodore R. Sarbin*. New York: Holt, Rinehart & Winston, 1961, 341 pp., \$4.00.

The subtitle of this paperback—The Experimental Approach to the Psychology of the Abnormal—suggests that this book is intended for supplementary reading for courses in abnormal psychology. But it will undoubtedly enjoy a wider audience, and deservedly so, for the book brings together 39 journal articles that report significant research in psychopathology. It is this reviewer's opinion that many recent anthologies could quite easily have been compiled by any graduate student selecting prudently from his faculty's list of required readings. However, in this book the hand of the editor is visible and for the most part deft.

The 39 articles are organized into nine general topic areas as follows: 1. Problems in Defining Behavior Pathology. 2. Alterations in Behavior Under Special Conditions: Possible Analogues of Pathological Processes. 3. The Employment of Learning Concepts in the Study of Behavior Disorders: Operant Conditioning and Stimulus Generalization. 4. Socialization Variables in Relation to Behavior Disorders. 5. Six Approaches to the Study of Schizophrenic Disorders. 6. The Investigation of Mood Disorders. 7. Psychophysiological Methods, Psychosomatic Syndromes, and Behavior Pathology. 8. Behavioral Consequences of Cerebral Disorders. 9. Prognosis in the Social Context.

The editor introduces each section with remarks about the significance of the section for the understanding of behavior pathology and discusses the articles included in the session. Personally, this reviewer would have welcomed a much more complete exercise of this function by an author so well informed as Dr. Sarbin. Some of the studies are seemingly contradictory, and commentary by the editor would have been helpful. Also, inadequacies in research design and faulty generalizations might bear editorial comment. For example, there is a less charitable explanation when prophecy fails than evoking the action of an unknown "suppressor" variable.

The book is relatively free from error, but there do occur such things as a reference to Bellak's *expensive* review of the literature and lack of a reference to Lykken's article having first appeared in the *Journal of Abnormal and Social Psychology*. This journal and the *Journal of Consulting*

Psychology are the source of the majority of the articles, although, in all, fifteen journals are represented. Certainly, all the articles in the book are significant in their own right, and many of them take on a much more compelling quality when presented in the setting provided by this volume.

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THE NATURE OF PSYCHOTHERAPY. A CRITIQUE OF THE PSYCHOTHERAPEUTIC TRANSACTION. By *Walter Bromberg*. New York and London: Grune & Stratton, 1961, 108 pp., \$4.50.

Bromberg's volume presents a thoughtful attempt to meet the challenge of the claims and counterclaims of many psychotherapeutic schools through a search for their common denominator. The writer considers himself a "lumper," an eclectic who searches for "connections, analogies and symmetries between things apparently as different as cabbages and kings." In this search he strips the therapeutic process temporarily of emotions and of theoretical constructs, and goes to the basis, the generic transaction of psychotherapy and its relational aspects. It is as if he were to search for the bare skeleton, stripped of flesh, blood, and muscles in order to find the nature of man.

He discusses the functions of the donor and the recipient, the patient-therapist dyad, and their respective premises. "What is being urged" in this book "is the clinical axiom that satisfactory and well-hypothecated treatment methods are superseded in time by others as theoretically satisfactory."

He relies on logic while discouraging commitment to theory, referring not to his theoretical position but to what he calls the views of the partisan theorist. "If such a development forces theory to be discarded in the interest of caring for the needs of mankind," he writes, "it may be a humbling experience for the partisan theorist but it diminishes no less the brightness of his accomplishments nor the world's appreciation of his tenacity and purpose in striving to make psychotherapy effective." Does he believe in the existence of an animal which is a nonpartisan theorist?

In his search for the common denominator he debunks both theory and emotion. While he thus sharpens our awareness of many vexing problems, he does not really solve them. Perhaps his wish is simply to ask questions with tongue in cheek which each therapist ought to ask himself and should try to answer. But even if the author succeeds in creating temporarily an unprejudiced *tabula rasa*, our answer must soon again consist of an attempt

to link experience to theory and technique to validation. Such is the way of science.

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FRONTIERS IN GENERAL HOSPITAL PSYCHIATRY. Edited by *Louis Linn*. New York: International Universities Press, 1961, 509 pp., \$10.00.

Keeping in style with "frontiers" in other fields, Dr. Linn makes a courageous attempt to clarify for his readers the progress that has been made in psychiatry during the past decade especially as it affects the general hospital setting. In order to do so, he has drawn on the experience of some 44 authors who have written 36 articles which are, somewhat arbitrarily, divided into four sections.

The difficulty in reviewing such a book can be illustrated by the diversity of the topics. They range from an illuminating article on the mental problems of Nigerians to a discussion of countertransference problems of physicians in the treatment of their patients. Under the heading of "New Patterns of Patient Care," Kalinowsky discusses such "old frontiers" as electroshock and, to this reviewer's amazement, regrets that psychosurgery has been a neglected field during the past few years.

There is much that should interest the individual reader, particularly those papers describing the efforts being made to improve the care of the mentally ill through better community services, day hospitals, short-term treatment centers, and moves designed to bring psychiatry and medicine closer. While much of this is not as new as the title would suggest, the book renders a valuable service in stressing the necessity of changing old concepts of institutional psychiatric care. It also throws light on the similarity of these problems in different parts of the world.

One by-product of the book, probably not intentional, is to bring to the reader's awareness the confusing and often contradictory methods which are being employed in the treatment of the mentally ill. We seem to have a much better grasp of the reasons for our past failures than an understanding of which direction we are heading in.

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THE EXPERIENCE OF REALITY IN CHILDHOOD SCHIZOPHRENIA. By *Austin M. Des Lauriers*. New York: International Universities Press, 1962, 215 pp., \$5.00.

This book is a welcome addition to the small but growing literature on the theoretical and clinical approaches to the problem of schizophrenia. The thesis advanced by Dr. Des Lauriers and repeatedly examined in many frames of reference is that the psychological experience of reality depends upon the existence of a functioning ego structure, that this is intimately tied to the establishment of a body ego, and that, consequently, the disturbance in schizophrenia represents the lack of formation or the fragmentation of this body ego.

The first half of the book concerns itself with laying the theoretical groundwork for the clinical application of this thesis and includes a careful and searching review of the literature on the etiology and approaches to the problem of schizophrenia.

Many exciting ideas and techniques, put into practice by the author, have resulted in a demonstrable improvement in the reality testing, and, therefore, a change from the psychotic to the nonpsychotic state, in his patients. The analysis of psychological test data provides validation of the theoretical framework as well as a measure of progress in the subjects treated by Dr. Des Lauriers.

The author is careful to emphasize that his approach to the therapy of the schizophrenic adjustment involves the careful and calculated ignoring of the symbolic meaning and content of the disturbance in order first to establish the body ego. It is only after the beginning formation of the ego structure as an integrating force that he helps the individual come to terms with the conflicts which he experiences and can now deal with because he has the organized mechanisms with which to cope, adapt, and modify.

His provocative ideas might well be applied also in the treatment of the younger autistic and symbiotically psychotic child. It will be interesting to follow the experiences of other investigators as they apply Des Lauriers's formulations and techniques to additional patients. Such an approach requires the well-trained and disciplined psychotherapist. Dr. Des Lauriers reveals himself throughout his book to be such a person.

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PSYCHOANALYSIS OF BEHAVIOR: COLLECTED PAPERS, VOL. 2, 1959-1961. By *Sandor Rado*. New York: Grune & Stratton, 1962, 203 pp., \$6.50.

Rado's second volume is an excellent exposition of adaptational psy-

chodynamics, a revised psychoanalytic theory based on Freud's early works (1892-1905) in which the mental apparatus was conceived of as a spatial and temporal arrangement of functions resting on physiological foundations and consisting of an unconscious system separated by repression from a conscious system. Adaptational theory does not embrace animistic concepts such as libido, the instinct theory, the id, the ego, and the superego.

The theory states that the human organism is adaptive, and through its goal-directed mechanisms it tries to fit its needs to its environment and its environment to its needs. Reality is defined in terms of action systems.

Rado believes that the chances for establishing physiological correlations in goal-directed behavior have been opened up by L. von Bertalanffy's "organismic" conceptions of biology, the determination of the properties of goal fields examined by Kurt Lewin and Thomas French, and the significance of "feedback" in goal-directed behavior first recognized by Julius Pikler and later explored by Norbert Wiener.

He considers the psychological treatment procedures of psychoanalysis and psychotherapy to be "medical" techniques which fall within the realm of psychiatry. He says that attempts to build a unified theory for psychiatry have been impeded by the still "unsolved problems of the mind-body relation." Adaptational psychodynamics is an effort to remedy this situation and is thus "fundamental to all medicine." An attempt is being made in the New York School of Psychiatry to educate members of the medical profession on a variety of levels in the use of this method of treatment.

Rado's organismic approach upholds the tenet that schizophrenia is an inherited disease and that some of the other mental problems such as obsessive-compulsive disorders are the result of a strong element of inherited defect. Psychotherapy is, therefore, of two types: reconstructive and reparative. Rado writes, "Strictly speaking, we possess at present only one reconstructive method, the adaptational technique of psychoanalytic therapy based on 'adaptational psychodynamics' which deals with the part played in behavior by both the organismic and the societal mechanisms of motivation and control. The class of reparative methods includes all other techniques of psychoanalytic therapy, hypnotherapy and certain troubleshooting and easing methods still in the experimental phase." Many will be unable to agree with Rado's genetic formulation with respect to the origins of neuroses and psychoses.

While Rado criticizes the instinct and the libido theories, he speaks of "innate emotions," the "primordial self," and the associated "stage of omnipotence." He talks of "inherited traits" which are obviously psychological in nature but which he says are static as opposed to the psychobiological organizations which are dynamic action systems. The psychodynamic cerebral system is a concept which would appear to be based on a theory of psychophysical parallelism, much like the libido theory, albeit in a dif-

ferent psychobiological context. One may suspect that Rado's use of such psychological systems as Kurt Lewin's rather than Moreno's is in keeping with his desire to fit mental phenomena within the framework and concepts of the physical sciences.

However, Rado's book is well worth reading for it attempts an integration of several kinds of psychological, biological, and genetic information, the blending of which is of great contemporary interest.

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GROUP PSYCHOANALYSIS. By *Norman Locke*. New York: New York University Press, 1961, 353 pp., \$6.50.

This book, reviewed here at some length as an indication of its significance, is a serious work, well written and well organized. I am impressed by the author's honesty of purpose, by his lively and interesting account, and by his valuable observations and illustrations.

The book is based on early traditional psychoanalysis. Interpretations in terms of the infantile neurosis are the hallmark. Other key concepts of psychoanalysis are discussed, such as transference, countertransference, "cross-transference" (transference between patients) identification, and projection, but without any particular reference to the group situation. The group is presented as a family under transference conditions, with the individual's dynamics unchanged. Psychodynamics manifest themselves in this situation in the same way as on the couch as far as the individual is concerned. Dr. Locke richly illustrates the workings and displays of these individual dynamics and, to a limited extent, their interaction. This is the best part of the book.

The decisive significance of the therapeutic setting in all psychotherapy, including psychoanalysis, for all processes is not recognized. In contrast, the author writes, "group psychotherapy does not employ the so-called group dynamics." The book completely and emphatically bypasses the group dynamics and therefore adds nothing specific to our knowledge of the individual and psychoanalysis nor to the technique or theory of group psychotherapy.

In the absence of sufficient information as to the therapeutic situation, we are left in the dark about the real significance of events reported. We turn, therefore, to the "Transcription and Analysis of a Group Session." We must say that this session has no recognizable similarity to group analytic sessions as we understand them. This does not necessarily mean that the groups Dr. Locke conducts are worse than the groups we conduct. It is,

however, important to realize that such differences exist and that observations and theoretical conclusions can often not be understood or communicated. I got the impression that conditions vary and are ill-defined, that, for instance, patients meet outside the therapeutic sessions, quite apart from alternate sessions, and that a married couple might be in a group in which the other members were unrelated to each other.

In spite of all this, the author cannot help approaching group analytic ground when he points out the mutual associative and interpretative significance of the members' communications. He does not appear to realize, however, the decisive theoretical implication of the concept "free group association" versus the original psychoanalytic one. Association for him still seems to be a product of the individual's isolated mind, which then interacts with and influences that of the others, and vice versa. Associations occurring in any particular situation differ according to the situation.

Concerning the selection of patients and the composition of groups, I agree with Dr. Locke when he says that the most fruitful procedure by which patients can be selected is not in terms of diagnosis but in terms of behavior. However, his statement that, "Therapists welcome neurotics, are not too happy about character disorders and psychosomatics, and try to avoid depressives and schizophrenics," is in no way borne out by our experience. One even wonders whether the author has in mind analytic groups at all when he says "the prognosis is unfavorable for neurological cases, arteriosclerotics, seniles and addicts." However, I agree that severe manic-depressives, autistic and withdrawn schizophrenics, and aggressive psychopaths are unsuited, though they might prove amenable under certain special conditions, as our work has shown and made theoretically intelligible. I also agree with his sponsorship of balanced and heterogeneous groups.

The use of the word "group psychoanalysis" for this and similar methods of group psychotherapy is not really helpful. One still has to find out each time what kind of psychoanalysis and what kind of group. What the author describes is the application of certain elementary psychoanalytic principles and techniques to a small number of individuals simultaneously sharing in the experience.

Criticism offered in this review does not mean that this book is not, on the whole, a positive contribution. The author's integrity and his competence as a therapist are undoubted. In addition, his theoretical and literary background appear to be of a high order.

S. H. FOULKES
London

BOOKS RECEIVED

- CHILDREN OF DIVORCE. By *J. Louise Despert*. New York: Doubleday, 1963 (95c) 307 pages (paperbound).
- INTERGROUP RELATIONS FOR POLICE OFFICERS. By *Charlotte Epstein*. Baltimore: Williams & Wilkins, 1962 (\$3.25) 203 pages (paperbound).
- TYPES OF FORMALIZATIONS IN SMALL GROUP RESEARCH. By *Joseph Berger, Bernard P. Cohen, J. Laurie Snell, Morris Zelditch*. Boston: Houghton Mifflin, 1962 (\$4.50) 169 pages.
- PSYCHOTHERAPY EAST AND WEST. By *Alan W. Watts*. New York: New American Library, 1963 (\$.60) 170 pages (paperbound).
- SPECIFIC AND NON-SPECIFIC FACTORS IN PSYCHOPHARMACOLOGY. Edited by *Max Rinkel*. New York: Philosophical Library, 1963 (\$3.75) 174 pages.
- THE AGING IN A CENTRAL ILLINOIS COMMUNITY. By *Bernard S. Phillips*. Urbana, Ill.: University of Illinois Small Homes Council, Building Research Council, 1962 (\$2.50) 101 pages (paperbound).
- RECENT ADVANCE' IN THE MEASUREMENT OF ANXIETY, NEUROTICISM AND THE PSYCHOTIC SYNDROMES. By *Raymond Cattell, Ivan H. Scheier, Maurice Lorr*. New York: Annals of the New York Academy of Sciences, 1962 (Vol. 93, Art. 20) pages 813-856.
- EGO SYNTHESIS IN DREAMS. By *Richard M. Jones*. Cambridge, Mass.: Schenkman, 1962 (\$4.50) 100 pages.
- INFANTS IN INSTITUTIONS. By *Sally Provence and Rose C. Lipton*. New York: International Universities Press, 1963 (\$5.00) 206 pages.
- A PRACTICUM OF GROUP PSYCHOTHERAPY. By *Asya L. Kadis, Jack D. Krasner, Charles Winick, S. H. Foulkes*. New York: Harper & Row, Hoeber Medical Division, 1963 (\$6.50) 203 pages.

A.G.P.A. NEWS

Edited by CHARLES G. McCORMICK, Ed.D.

GOLDEN GATE GROUP PSYCHOTHERAPY SOCIETY

The Fifth Annual Scientific Conference of the Golden Gate Psychotherapy Society was held on Saturday, June 9, 1962. A regular monthly scientific meeting held on October 2, and future meetings through the spring of 1963 have been reported.

Meetings are scheduled on Tuesday evenings at Langley Porter Neuro-psychiatric Institute on the subject of "The Therapist and His Treatment Contribution in Therapy Groups." Spring dates listed are: February 5; March 1; April 2; and May 7 at 8 P.M.

Last fall, two meetings on the same theme presented William C. Schutz, Ph.D., of the University of California, Department of Education, in Berkeley; and Virginia Satir, M.S.W., of the Mental Research Institute, Palo Alto. Eric Berne, M.D., Erika Chance, Ph.D., and Martin Steiner, M.D., participated as panelists.

The University of California Medical Center, San Francisco, was the meeting place for the Society's Fifth Annual Scientific Conference. The program included a variety of topics, both within and outside the discipline of group psychotherapy: "Family Group Counseling"; "Process-Focused Consultation with Staff Groups"; "Group Therapy: A Social Institution"; "Conard House: A therapeutic Community Hostel"; "Structure and Process in the Treatment of Two Male Homosexuals in Group Psychotherapy." There were several papers presented on "Transactional Analysis" and "Family Group Therapy."

The Workshop leaders were Donald Shaskan, M.D., Eric Berne, M.D., David Kupfer, Ph.D., Erika Chance, Ph.D., Hugh Coffee, Ph.D., Charl Rhoad, M.S.W., Roderic Garney, M.D., and Molly Goldberg, R.N.

A Luncheon Meeting featured an academic lecture by Edward Stainbrook, M.D., Professor of Psychiatry, University of Southern California. The subject was: "Training for Group Therapy and of Group Therapists." M. Robert Harris, M.D., of San Francisco was the discussant.

Among those who presented special papers and contributed as discussants were: Samuel Slipp, M.D., and Isadore Kamin, J.D.; James Peal, M.D.; Charles O'Shea, M.S.W.; Donald T. Brown, M.D.; Kenneth Everts, M.D., and Franklin H. Ernst, M.D.

Also lecturing were: David Kevin, M.S.W.; Earl Cohen, M.D.; Gordon W. Gritter, M.D.; D. Leonard Miller, M.D.; Martin Steiner, M.D.; Joseph P. Concannon, M.S.W.; and Andrew Curry, M.S.W. Chairmen for the sections were: David F. Shupp, M.D.; William Collins, M.S.W.; Donald Shaskan, M.D.; and Erika Chance, Ph.D.

The Society's officers for 1962-1963 are: President, Charles O'Shea, M.S.W.; President-Elect, Martin Steiner, M.D.; Past President, Erika Chance, Ph.D.; Secretary, Franklin Ernst, M.D.; Treasurer, David F. Shupp, M.D.

TRI-STATE SOCIETY

"The Function of the Group Psychotherapist in Various Settings" was the topic of the Tri-State Society's fall meeting, October 24 and 25, 1962. The Northern Indiana Psychiatric Society and the State of Indiana Division of Mental Health cooperated with the Society in this presentation which took place at the Pick Oliver Hotel in South Bend, Indiana. A panel discussion, Workshops, and a Dinner Meeting were the principal events.

The guest speaker at the Dinner Meeting was Aaron Stein, M.D., of New York City. Other participants, both on the Thursday morning panel and the afternoon Workshops, were Theodore A. Hill, M.D., of South Bend, and Stanley L. Block, M.D., of Cincinnati.

SOCIETIES IN FORMATION

The Michigan Society for Group Psychotherapy has announced two general meetings held last spring and fall. The Society has changed its name from Michigan Group Psychotherapy Association, in order to conform to the AGPA constitutional requirements for affiliation, and regular officers have been elected.

Both general meetings of the Society concerned themselves with practices other than that of group psychotherapy. The June 15 meetings at the Merrill-Palmer Institute in Detroit presented two papers: "The Social Group Work Method in Therapy," by Virginia Crowthers, M.S.W., and "Group Social Activity for Convalescing Mental Patients," by Leon Lucas, Ph.D. Both speakers are on the faculty of the Wayne State University School of Social Work.

A meeting on November 7, at the Wayne County Youth Home, presented Ronald Lippitt, Ph.D., of the Center for Group Dynamics at the University of Michigan. The subject considered was, "Dimensions in Creating a Reeducative Experience."

The new officers for the Michigan Society are: President, Albert W. Silver, Ph.D.; Secretary, Catherine Quinlan, M.S.W.; and Treasurer, Robert Doering, M.A.

INTERNATIONAL NEWS

Edited by HERMAN TANNOR, M.D.

ARGENTINA

The *Revista de Psicología y Psicoterapia de Grupo*, which appears bi-annually, is now in its second year. Those interested in the activities of Group Psychotherapy in Argentina should write to the following address: *Revista de Psicología y Psicoterapia de Grupo*, Av. Libertador General San Martín 222, Buenos Aires.

The Argentina Society participated with the following papers in the 3rd Congress Latinoamericano de Psicología y Psicoterapia de Grupo which took place in Rio de Janeiro, July 16-19, 1962: "The Training of Group Psychotherapists," "Evolution of Therapeutic Groups," "Ideological Groups."

Major trends in Group Research and Therapy are as follows:

Dr. Luchina et al. are working in psychosomatic medicine, especially with cardiac patients being treated with a pacemaker. They are using group psychotherapy in this investigation.

Drs. Puget and Usandivaras are working with small groups for teaching and investigation at the Universidad Católica de Buenos Aires. Dr. Usandivaras has devised a special test with marbles for investigating family groups. Drs. Rolla, Vidal, and Langer are also working with family groups in private practice and hospitals.

Dr. Pichon Riviere has organized the Instituto Argentino de Estudios Sociales which uses "operative groups" for study of communities.

Drs. Alvarez de Toledo and Perez Morales y Fontana are continuing the investigation of LSD 25 in groups.

Dr. J. J. Morgan et al. are working in the Hospital Nacional de Neuro-psiquiatría in a therapeutic community setting using groups of mothers and psychotic sons as well as an experimental group of schizophrenic patients.

In the College of Medicine, Drs. Garma and Rascovsky are conducting groups with medical students.

Dr. Bleger, Professor of Psychology at the Universidad de Filosofía y Letras, conducts student groups.

Drs. Rojas Bermudez, Paulovsky, and Abadi have been using psychodrama for the study and treatment of patients.

AUSTRALIA

Victoria

There has been further progress in the use of group therapy in the treatment of children, adolescents, and their parents, in psychiatric outpatient clinics.

In the mental hospitals, groups are used for the treatment of alcoholics. There are also attempts to establish a therapeutic community through the

introduction of mixed groups of long-term patients.

The day hospital, predominantly for neurotic patients, is almost entirely group-centered.

The use of group-dynamic methods in the training of various professional personnel such as clergy, general practitioners, nurses, children's homes staff, youth leaders, marriage counselors, etc., has become widely accepted; role playing and sociodrama have proved a most effective means of making participants aware of all the forces operating in a group.

An interesting experiment is being carried out in one of the psychiatric clinics where a professional staff group is supervising the treatment of a patient by one of the psychologists.

A group has been formed by senior psychiatrists to discuss their cases and their own involvement in treatment.

The pilot study on the treatment of male youthful offenders by group-psychotherapeutic methods continues at the psychiatric clinic, H. M. Gaol, Pentridge. Difficulties exist due to limited staff and accommodations, resulting in all psychiatric cases being housed in one section. Selection of group members has been changed from segregation based upon crime and age to groupings based on degree of socialization and motivation toward real change of personality. At present, age, offense, level of intelligence, and education vary widely in all groups, but care is taken to avoid singular isolation by using the Noah's Ark principle of Kraupe Taylor wherever possible. There are at present four prisoner groups and group therapy is limited to one and one quarter hours per week per prisoner.

While the groups are conducted by a psychiatrist, Dr. J. Allyson Levick, the staff psychologist, E. N. Plumridge, attends as observer. This practice allows heightened observation and wider interpretation and therapeutic interchange. To remind the offender that he is in the psychiatric division for a particular purpose, it has been found useful to bring together the entire prisoner personnel and all available staff for half an hour each working day. This is a period of easy communication between prisoners and custodial and therapeutic staff, as well as an attempt to prevent staff manipulation by the prisoners. Early problems are being successfully overcome and there is wider appreciation of the daily group as a means of ventilating encapsulated group situations of an explosive emotional nature, with consequent improvement in division atmosphere.

In the five months that this approach has been in operation no prisoner has required transfer to the punishment division for breaches of prison regulations. It is hoped that an article on the use of group psychotherapy with male youthful offenders in jail will be published in the journal.

South Australia

From Adelaide Dr. J. E. Cawte reports that group psychotherapy continues to be an important aspect of work in the Mental Health Department, although not elsewhere. A chief focus is Enfield Hospital which regards it-

self as a group-centered hospital rather than as a therapeutic community. This usage expresses: (1) the prevailing doubt about what the therapeutic process consists of; (2) a reaction to exaggerated claims made in some quarters in the name of the "therapeutic community"; (3) a concern for the group dynamics of the psychiatric hospital as well as for group psychotherapy per se. This perspective is illustrated by the publication "Assent and Dissent in an Unlocked Mental Hospital" by J. E. Cawte and L. B. Brown (*The Medical Journal of Australia*, 1:644, 1962).

New South Wales

From Sydney, Professor D. Madison reports that Dr. John Shand has recently rejoined the staff of Broughton Hall Psychiatric Clinic. After a year of postgraduate training at the Phipps Clinic in Baltimore, he is planning a further expansion of the group therapy program in this hospital. The study of group therapy in a therapeutic community setting by Dr. N. T. Yeomans is still proceeding and long-term evaluation is being attempted of the results achieved in patients with major personality disorders.

The New South Wales Association for Mental Health continues to use group training programs in many of its activities. During the past year group methods have been employed in the postgraduate education of such miscellaneous groups as mothercraft nurses, occupational therapists, clergymen, parole officers and women police. A group training program has run through the year for the education of group leaders. In addition, the Community Education Committee of this Association further extended its program of parent education by using group discussion under trained lay leaders.

Western Australia

Dr. J. Stubbley reports:

The Graylands Day Hospital functions as a therapeutic community with large or community groups, and small groups. Individual psychotherapy has been in operation since April 1959.

In a daily average population of 110, about one third are adolescents and two thirds are adults. Diagnostic categories of neuroses, personality and behavior disorders and borderline psychotics make up the bulk of the community.

Small groups are broadly divided into a wide range of homogeneous groups (marital problems, phobic anxiety, sexual deviant, etc.) and heterogeneous groups. Creative activities such as art and pottery may be used to facilitate interaction, while puppetry, psychodrama, and psychiatric films are also used within certain limits. Other groups emphasize the acquisition of social skills, occupational or industrial activation, and educational needs.

Training of staff is predominantly along nondirective lines, but varies according to the bias of therapists. General trained nursing staff are given

an inservice course of psychiatric training. The Havelock Clinic (out-patient) has a social therapy unit which provides afternoon and evening sessions with emphasis on the acquisition of social skills and socialization. Group discussions under the clinic psychologist are under way.

Heathcote Mental Hospital has instituted group discussions in the setting of a therapeutic milieu.

CHILE

The Sociedad Chilena de Psicología y Psicoterapia de Grupe has increased the number of its members to 37. Its present board of directors consists of: President, Dr. Guillermo Gil; Vice President, Hector Pauchard; Secretary, Ketty Grass; and Treasurer, Dr. Alberto Robinson.

The society held 20 meetings during 1962. A few of them were devoted to clinical material, mostly from groups of alcoholics. There were several papers on therapy with psychotics, juvenile delinquents, and neurotic adolescents. Other papers dealt with the evolution of therapeutic groups, relationships between observer and conductor, and a pilot study on human relations training applied to teaching policies at the Medical School of the Universidad de Chile (this plan used the "T-Group" technique of the National Training Laboratories).

Several members attended the Third Latin American Congress on Group Psychotherapy held in Rio de Janeiro during July.

Group psychotherapy is being used as part of the psychiatric training of medical students at the Psychiatric Clinic of the Universidad de Chile. Various types of group therapy are used in several hospitals.

THE NETHERLANDS

The Nederlandse Vereniging voor Groeps-Psychotherapie now consists of 88 members. There were no changes in the Board.

A multidisciplinary study group of psychologists, psychiatrists, and sociologists has been organized, and has begun to hold meetings.

PERU

Dr. Carlos Alberto Seguin has been appointed Professor of Psychiatry and Chairman of the newly created Department of Psychological Sciences in the School of Medicine of the University of San Marcos. He reports as follows:

We are interested in the research and application of Group Psychology and Psychotherapy. We have organized "working groups" for the medical students. Every student, from the first day of his admission, will belong to a group which will meet once a week throughout the year for all the five years of his medical studies. In this way we hope to accomplish several objectives: (1) to study group dynamics in the student milieu; (2) to provide

students a means for handling their emotional problems; (3) to give students the opportunity to learn first hand applied psychology and psychodynamics; (4) to establish a better relationship between teaching staff and students. We hope in the near future to be able to collect some interesting observations and to present them in a systematic fashion.

SWEDEN

Dr. Thorsten Sjövall is the newly elected President of the Swedish Society of Group Psychotherapy which was organized in 1961. He also will replace Dr. Herulf, recently retired, as Corresponding Editor for this Journal.

SWITZERLAND

Group psychotherapy in Switzerland is used especially in the Psychiatric University Clinic and Policlinic of Basle (Director: Professor P. Kielholz), in the Psychiatric University Policlinic of Lausanne (Director: Professor P. B. Schneider), and at the Psycho-Hygienic Institute of Biel-Bienne (Director: Professor A. Friedemann). In the past year all three centers established teaching groups with physicians and great interest was noticed for this training. This was also the case with self-experience groups held at the "Medical Studies Week" at Sils (Engadine), September 9-15, 1962.

At the spring assembly of the Swiss Psychiatric Association, Dr. Battlegay discussed group psychotherapy with dissocial juveniles.

ANNOUNCEMENTS

The 3rd International Congress of Group Psychotherapy sponsored by The International Council of Group Psychotherapy will be held from July 18-21, 1963, at Milano-Stresa, Italy. For information regarding registration and participation in the program write to: The International Council of Group Psychotherapy, P. O. Box 311, Beacon, N. Y.

CAPP, The Conference for the Advancement of Private Practice in Social Work, will convene for its Second Conference, Saturday and Sunday, June 15-16, 1963, at the Denver Hilton, Denver, Colorado. Those interested in attending or wanting information regarding the Conference can write CAPP's secretary: Mr. Paul Ledbetter, Suite 1529, Medical Arts Building, Houston 2, Texas.

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GROUP PSYCHOTHERAPY AND MENTAL HEALTH

JACK R. EWALT, M.D.¹

The Final Report of the Joint Commission on Mental Illness and Health (1959) contains findings that have special relevance to group psychotherapy. As one of the authors of the Report, I should like to discuss these findings.

To consider, first, the scope of the problem of mental illness, one person out of one hundred has a severe disorder that is socially disruptive or individually incapacitating. In a nationwide survey of Americans' views of their own mental health, it was found that one in four adults at some time had had a psychological problem in which professional help would have been useful, and one out of seven had actually sought help. The Midtown study found about the same number to be suffering from some form of mental malfunction. But mental health facilities and skills of all kinds are inadequate.

As noted in the Joint Commission Report, the lag in the treatment of the mentally ill is the result of a long-time, fundamental pattern of social rejection. The Report points out that society sees the mentally ill person as a threat: "We can name a number of processes, all of which add up to, or reinforce, the fact that the mentally ill repel more than they appeal. One characteristic of a psychotic is that he becomes a stranger among his own people. Since antiquity mankind has been prone to feel hostility toward the stranger, and this applies equally to any persons who behave strangely. A social system depends on order, and order depends on predictability in the behavior of one's fellows.

"Normal persons for the most part want to do what they have to do to 'get along.' The typical psychotic does not. In consequence, society conventionally closes ranks against him. Identified major mental illness carries a stigma that cuts the bonds of human fellowship."

The Report goes on to state: "It is not so much his symptoms themselves that bring the psychotic patient into a mental hospital . . . but that his behavior reaches a point where people no longer can stand it. . . . It is basically that normal people are disturbed by the patient's refusing to comply with expectations of time and place. . . . It should now be clear that one way around the impasse of public and professional attitudes that we appear

¹ Professor of Psychiatry, Harvard Medical School; Superintendent, Massachusetts Mental Health Center, Boston, Mass.

to have erected would be to emphasize that persons with major mental illness are in certain ways *different* from the ordinary sick."

Since we first made this statement, a survey in at least one community shows that people express less fear of or rejection of persons who are mentally ill. This has been interpreted as evidence contrary to our thesis about rejection, but I do not so interpret it. We were familiar with a much earlier survey by Shirley Starr which clearly demonstrated that people have long made the appropriate answers to questionnaires of this sort; they talk like psychiatrists but they cannot and do not apply these intellectual attitudes to actual clinical situations. They deny the existence of mental illness in all but extreme cases. We said, and still believe, that society's neglect of and failure to treat large numbers of mentally ill and retarded persons can best be interpreted as a wish to avoid and deny the problem and to reject those who are ill. It is true that some progress has been made, but a visit to all the wards of any state hospital will reveal the extent of that progress. Much of the activity stirred up by the Joint Commission Report has been in relation to community facilities. Our proposal that the neglected chronic psychotic be given first-class treatment that uses the techniques developed for many chronic diseases has been rejected as unsound or overlooked entirely.

In other words, it is painfully clear that society itself needs therapy; that is, society's expectations of the mentally ill are inappropriate and harmful to all concerned. The basic assumption of group therapy is that the patient is a member of a group, involved in a mutual relationship. In this case the group's attitude toward him is one of fear and rejection. The effects of such an attitude (including the ways in which society chooses to deal with the problem) are obvious. The Commission Report says: "Human beings regard loss of liberty, forcible detention, removal from the community, and imprisonment as punishment for wrongdoing; the mentally ill are no exception. It is generally agreed that the typical locked-ward state hospital, centering its interest on the physical rather than the mental welfare of the patient, increases the patient's disability by reinforcing rather than counteracting public pressure to reject the patient from the community. As the pioneer reformer, Clifford Beers, said, 'Madmen are too often man-made.'"

The Commission in 1959 reported the following: "One of the most revealing findings of our mental health study is that comparatively few of 277 state hospitals—probably no more than 20 per cent—have participated in innovations designed to make them therapeutic, as contrasted to custodial, institutions. Our information leads us to believe that more than half of the patients in most state hospitals receive no active treatment of any kind designed to improve their mental condition. This is the core problem and unfinished business of mental health."

But if the business is unfinished, at least the work has been started, and

today a much larger number of hospitals offer treatment to some, if not all, of their patients. The concept of the therapeutic community (as opposed to the custodial institution) represents one of the major advances in care for the mentally ill. Traditional mental hospital care includes the following elements: the admission experience may be traumatic; communication is restricted; the patient sees himself as entirely dependent on the staff and his sense of personal identity is weakened; the patient's behavior is guided by the hospital privilege system, which rewards passivity and conformity; the hospital atmosphere is one of authoritarianism and impersonality.

The "open hospital" and "therapeutic milieu" approach to hospital management is actually a kind of group therapy; the underlying idea is that group assumptions, expectations, and attitudes will be adopted and acted upon by the patients. To put it very simply, to a certain extent patients behave the way you expect them to behave. Our view of the mentally ill is especially important since they are acutely aware of what that view is and base their behavior on it. In *The Fields of Group Psychotherapy*, Slavson (1956) says: "The mentally ill are extremely sensitive, and great pains need to be taken not to do anything that widens the gap between them and their fellow creatures . . . whatever the ultimate cause, mental illness in its turn always leads to a disturbance in social relationships . . . mental illness always leads to loneliness, subjectively as well as objectively."

The therapeutic community tries to counteract this loneliness by abolishing those attitudes and practices which foster physical and emotional isolation and alienation; it attempts to draw the patient back into the social family. Slavson (1956) says: "... resocialization will be an essential aim, and group therapy in the widest sense of the word, including direct psychotherapy and occupational and recreational therapy, is the most practicable and satisfactory way of dealing with this task. . . ."

Slavson (1956) observes that, aside from its ability to treat larger numbers of patients with a more limited number of therapists, group therapy has certain aspects which individual therapy lacks: "The setting of group therapy is a much less artificial one and less remote from lifelike conditions. Furthermore, individual therapy as well as other specific therapies can only occupy a relatively short segment of the patient's time in the hospital. It is of the utmost importance that his whole day should be well planned and occupied usefully. In these groups the patient has the opportunity, perhaps for the first time in his life, of gaining a feeling of belonging, of security, of confidence, and an increase in self-esteem and happiness. Living, working, enjoying life, discussing problems side by side with others who have more or less similar difficulties, gradually lead to a lessening of feelings of isolation and loneliness, increase interest and participation, and alter attitudes from egocentricity to greater altruism and community-mindedness.

"Stimulation by interaction of thought and feeling with others increasingly improves one's 'social ego,' and as all these activities take place in a completely free atmosphere, the patient's sense of freedom leads to a heightened feeling of responsibility. The intermingling of the sexes in occupational, recreational, and discussion groups, too, makes the hospital experience more like real life and helps remove the feeling of being cloistered and living 'apart' from the rest of the world."

In the therapeutic community the patient is seen as capable of exercising self-control and assuming some degree of responsibility. Group standards are more readily internalized than are mechanical restraints that foster loss of control. The group encourages self-respect and decision-making, and helps to correct cognitive distortions and faulty behavior patterns.

Many of the principles underlying the therapeutic community are also applicable to other group work. Lena Levine (1956) states: "Group techniques emphasize the universality of basic needs, the uniqueness of the individual and the inevitably resulting differences in behavior and attitudes." This is true regardless of the exact nature of the group itself or the specific kind of techniques that are being employed. However, it is obvious that the aims of all therapeutic groups are not the same. In certain group work the desired result is socialization, while in sociodrama "there may be an acting-out of conflictual situations which have social implications" (Hinckley and Hermann, 1951). Nor are all kinds of group therapy of equal value. At the Massachusetts Mental Health Center we have many kinds of groups, some composed of patients, some of patients' families, some based on body weight, and a program of family therapy which is usually used in conjunction with group and individual therapy for chronic schizophrenics. Scheidlinger and Freeman (1956) point out: "Group therapy would appear to be a particularly suitable service for a family agency to develop. It is well known that personality formation or malformation has its roots largely in the individual's experience in his first group—the family. Family conflicts are spontaneously reenacted in such a setting; they can be corrected through the supportive elements inherent in the group experience. The reality of a group of people, each with his own needs and reaction patterns, offers an opportunity for testing and modifying one's own social behavior."

While the varieties and advantages of group therapy are familiar and need no elaboration, it may be useful to remark on some of the unfinished business of group psychotherapy; that is, the need for further research on the nature of groups, on what the individual and what the group can do, on how much is essential and how much is irrelevant in the process and setting of group therapy (as well as in individual therapy).

Some groups have a psychoanalytic orientation to theory, goals, inter-

pretation, and emotional interchange. Others seem to be based on learning by conditioning techniques. Some groups are based on theories of social interaction or interpersonal transactions colored by psychoanalytic and Sullivanian theories to varying degrees. Some groups have as their avowed goals the learning of work habits and skills that are socially useful, but the interpersonal transactions may be quite similar to the more traditional "sitting and talking" groups. Some sing, dance, act, read, or collect shells. I suspect that the advantages of one orientation over another are not really known. What are reasonable goals for any kind of group therapy, and do they differ for the different forms? Can we agree on how to specify a desired result, conduct a group therapy experience designed to achieve it, and have a reasonable expectation of success? There are no reliable data on the percentage of success with group therapy. Indeed, how many controlled experiments are there with any kind of psychotherapy, group or individual?

We all sense that things happen to people in groups, but I doubt that we know much about why, and we need to know. We bring in verbal analogues from individual therapy to describe group transactions; occasionally they may be appropriate, but often they merely add to the confusion. And often one word is used in several ways, "transference," for example.

In a sense, there will always be unfinished business, and luckily so. We can never really know enough about any aspect of human behavior, and this includes the dynamics of groups. It is especially important that we intensify our research in this area now. Our concept of groups is changing. There was a time when anyone who lived half a mile away was a stranger, but as our population grows and transportation improves, we can less and less afford to think in terms of "others" as being importantly different from ourselves; in fact, our very survival depends upon our willingness to admit that we are all one group and that what harms some of us harms all. There is no longer room in the world to run away and hide. We must all be able to talk with and deal with one another. We dream and hope and work for world peace. But we do not yet know how to persuade people to operate automobiles in a safe and sensible manner. We aspire to get on with those of different cultures, languages, and religions before we know how to eliminate violence arising from intolerance, labor problems, or social neglect in a rich nation. We don't even know how to persuade people to supply adequate medical service or education to all levels of our society. We have seen demonstrations that suggest to us that, difficult as it may seem, some of these things can be done. Group psychotherapy and studies on group phenomena have indicated some of the ways we can accomplish some of these goals now if we want to. But our knowledge is still too crude and our techniques too general.

Still, I am hopeful about the future, to a great extent simply because

we know that we don't know enough and because we care. As the poet Jimenez (1956) has said: "When we contemplate things and beings, when we love them and enjoy them, when we have their confidence, having given them ours; when we concern ourselves with them through our complete consciousness and, as a complete consciousness, they manifest their content to us, we shall possess their most profound secrets and thus they will be able to offer themselves to us as an ideal, for perhaps the ideal may be a secret of which only the loving are worthy."

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SOME RELATIONSHIPS BETWEEN GROUP PROCESS AND MENTAL HEALTH PHENOMENA IN THEORY AND PRACTICE¹

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In a paper published over a decade ago entitled "Group Psychotherapy and Mental Health" (Peck, 1951), I urged that group therapists not "limit the scope of group therapy to that of simply another (psychotherapeutic) technique or device." I suggested that, rather, we should learn how to establish and conduct groups "within the moving currents of community life" so as to exert a significant effect upon the structure of our social institutions. I expressed the hope that in this way we might "change not only people but institutions . . . (and) begin to get cumulative effects of a sort that will really make the mental hygiene dream come true."

In the ten years or so since the recitation of the above "dream," many therapists have been busily engaged in attempts to extend knowledge and skill derived from work in group psychotherapy to the tasks and problems of the mental health movement. It would be difficult and perhaps embarrassing to try to evaluate the usefulness of our efforts by any measurable impact on the effectiveness of mental health programs. Several recent critical evaluations (Kotinsky and Witmer, 1955, and Evaluation in Mental Health, 1955) of such programs frankly conclude that there is little substantial evidence that any of these programs can unequivocally prove their contributions to either the maintenance of mental health or the prevention of mental illness. In addition, the prevailing and unresolved vagueness about the very concepts of "prevention" and "mental health" abet the general confusion.

Nevertheless, I believe that cross-fertilization between group psychotherapy and public health psychiatry gives promise of improving the strains in both fields and even of producing a number of viable hybrids. This rather optimistic view is derived largely from my own successes, failures, and surprises encountered in the course of endeavors ranging from crude attempts to fashion group therapy techniques that meet the requirements of mental

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health programs to rather painful efforts to clarify certain of the basic concepts about groups and health. In surveying some of the more persuasive theoretical constructs currently offered as models for thinking about the nature of mental health, one can discern some common elements even among such divergent views as those of the clinical psychiatrist, psychoanalyst, social psychologist, sociologist, and anthropologist. All are content ultimately to refer their formulations back to the biological model and more or less concur that, in common with the amoeba, the flatworm, and his fellow vertebrates, man's optimal functioning, no matter how defined or measured, depends on his ability to collect and assemble data regarding his environment so as to maintain control of his relationship to the significant universe. Most writers agree that, for man, other humans constitute that aspect of the environment most intimately concerned with mental health.

Few would disagree with Eaton's (1951) statement that "mental health is a conceptual abstraction involving relativistic assessment of man's relations to himself, his society, and his values . . . and that it cannot be understood in isolation from those manifestational phenomena that constitute a person as he functions in society."

In the current mental health literature we find reports on functioning "in society" based on data collected by the traditional methods of the sociologist and anthropologist. These together with the application of biostatistical techniques would appear to place us a little closer to the beginnings of an epidemiology of mental health and mental disorder. But, unfortunately, this body of knowledge still largely defies translation into terms which are meaningful to the clinician. The conceptual gap is still very great between the intrapsychic and the societal, the frameworks of reference of the psychoanalyst and epidemiologist. To make matters even worse, we still seem to have difficulty in deciding when our disparate views reflect entirely different sources of raw data, varied interpretations of the same data, or differences in integrative level or observational instruments. Despite these enormous obstacles, it is evident that the distance between these two bodies of knowledge and practice must be bridged if we are to have either the conceptual tools or the technical means required for a better understanding of the nature of mental health, much less a way of intervening planfully in the processes by which it may be maintained and mental illness prevented.

My own experience and that of other colleagues who have been working with small groups over the past decade or so leads us to believe that *the small group potentially is one of the major means for bridging the gap between these two worlds, that in the small group we can catch simultaneous glimpses of the societal and intrapsychic, and that through such glimpses we may begin to interrelate phenomena at the individual and*

community levels and thus better integrate the observations and concepts of the psychoanalyst and the social scientist.

THE DELINQUENT, THE ANALYST AND THE GROUP: TWO WORLDS MEET

To illustrate the kinds of conceptual and technical problems encountered in the worlds brought together by a small group, let us take a look at some of the transactions when a psychoanalyst and an adolescent delinquent encounter each other in a therapy group.

The adolescent is there because he sat in hostile silence during six months of fruitless efforts to involve him in individual psychotherapy and because he dare not say no to the agency's suggestion that he come to the group lest the court send him to the reformatory. The analyst, frustrated in his efforts to conduct individual treatment with this adolescent, reluctantly accepts the role of group therapist because he is desperate. In the very first group session, the hitherto-silent adolescent monopolizes the session with his "preaching" pronouncements on sin and evil. In the same group, there is a lad who had successfully stymied the efforts of the therapist by his compliant, "Yes, sir, No, sir," in the individual sessions, while defying the world and raising general hell between times. In the first group session, he tauntingly offers the therapist a marijuana cigarette, and then almost collapses with the first overt evidence of acute anxiety manifested in the therapist's presence.

If we have a notion that any one view of either of these youngsters is more "real," more "typical," or more revealing of the "psychodynamics," we need only see these same boys together with their families or on the "turf" occupied by their neighborhood gang. Such contrasting views help keep our confusion alive and make us long for the comfortable world where we know "for sure" that if only we can induce the individual to visit us three or four times a week, assume a prone posture facing away from us, and agree to report every thought, feeling, dream, and sensation that occurs, then we will know who and what he really is and be better able to make judgments regarding the nature and extent of his psychological illness and health. As a psychoanalyst, I do not really want to give up such a bias. Nevertheless, I cannot avoid being confronted by the absurdly self-evident fact that *people behave differently in different group situations* and that some of these differences pertain to aspects of illness and health which are of considerable interest to me. For, whether I am wearing the hat of an analyst, social scientist, or public health psychiatrist, I find it very intriguing that *in a more or less planful way, I can bring about group situations in which the individual appears to me (a) more or less "sick" or pathological and/or (b) more or less "healthy" or competent.*

Despite my delight at this rather naive discovery, I am also perplexed. If I am to use it as a guide as to how I am to conduct myself as a therapist in this or other groups, I must try to become a little clearer about what I mean by "sick" and "healthy" in the "group situation" and how this situation differs from the "individual situation." Did the boy who offered me the "reefer" upon entering the room, after months of no contact in individual treatment, do so because he could or had to behave differently toward me in the presence of his peers; or did I behave differently toward him because he and I were not alone? If it was both of these, which came first? Was the anxiety I saw in the boy in the group really present in the individual sessions but less apparent without the group background?

The very asking of such questions suggests the problems likely to be encountered if an attempt is made to answer them one by one without conceding the possibility that each of these possible actions and reactions are dynamically interrelated. We are, I believe, in real trouble if we persist in viewing the group situation as a collection of individuals or the sum of fragmentary actions and reactions without acknowledging that, when we bring the two boys in the above illustration together with the therapist, we may be creating another kind of world related to, but different from, the one from which the actors came. In this new group world, each of us may behave differently and the interactional pattern between any two actors may be changed by a third, who may alter his mode of behavior accordingly, etc.

In other words, we may refer to this new "group situation" as one characterized by its own unique set of interactions within which context the behavior and perception of reality, of self and of others, by each member, *including the therapist*, may be expected to change. Of course, the mere bringing of the three of us together with or without the other boys does not in itself constitute what Redl (1942) refers to as the "group formative process." Until this does take place, we will not have become, in Bales' (Parsons and Bales, 1955) terms, "a system in interaction" so that "a change of state of any 'X' (unit) be followed by a change of state in the remaining (units), which is in turn followed by a change in the state of 'X,' etc."

As nearly as I can recapture the clinical situation, Bales has described in abstract terms pretty much what I as the clinician-therapist experienced. I know that even as I entered the room with a number of boys in it, rather than the one boy I was accustomed to, I moved, thought, felt, acted, and spoke differently. I can recall thinking with some surprise and a twinge of apprehension, "These guys together could take me if they wanted to." I am reasonably sure that at least some of the boys viewed my entrance quite differently than when they were alone in the room with me. I am almost certain I saw these feelings about me (positive and negative) communicated to their peers before a word was spoken. I had anticipated that the

lines of communication would, at first, reflect the former dyadic groupings of boy-therapist. Within minutes, however, the boys were "having a ball" among themselves and I felt myself almost pleading with them to let me join "the gang." They did, when *their* leader gave the sign by accepting one of my cigarettes after the others had consistently refused until he signaled them in this way.

This is how it seemed to me. I have no way of persuading anyone else that this was the way it was. I suspect that with a slow-motion sound movie it would appear somewhat different even to trained observers with a background similar to mine, and perhaps even to me. I am even more certain that these happenings were perceived in radically different terms by each of the boys. However, if I had that sound movie, the one thing I am quite sure would be generally evident is that within those first few moments we did have a group in the process of formation, a new psychosocial entity, the sum of which was different from any of its parts, a group capable of maintaining homeostasis, developing boundaries, a personality, and a level of competence of its own, including the potential for both perceiving and distorting reality.⁸

This individual-group analogy (Individual-Group Psychological Isomorphism) construct is particularly useful in enabling us to play back and forth between the group and the individual and to integrate our view of reality from both the group and individual integrative levels in some coherent way.

HEALTH AND THE ASSESSMENT OF REALITY IN THE GROUP

The usefulness of the group in assisting its members to arrive at a more accurate and realistic consensus is so familiar a phenomenon to the group therapist engaged in the treatment of pathological distortions of reality that it would seem to require no further elaboration. Slavson (1959) essentially speaks for the field when he says "... the mirror reactions of the other patients and their direct attacks upon the defensive machinations of the ego, which alienated the patient to varying degrees from himself and outer real-

⁸ When I refer to a group in these terms, I am invoking the logical construct of "Individual-Group Psychological Isomorphism" (I.G.P.I.) first suggested by MacDaugall, Lewin, Glover and others, and which has been characterized by my colleagues, Melvin Roman and Gerald Bauman (1960), as follows: "... psychological organization of groups is fundamentally similar to that of individuals. That is, groups can be characterized as dynamic wholes having psychological attributes of their own, including intelligence and personality. Also, the personality and intelligence of a group are emergents. They are the unique products of the interaction of its members and, therefore, cannot be deduced simply from knowledge of the personality and the intelligence of individual members."

ity, are among the major advantages of group treatment." Yet, our colleagues in the field of mental health, concerned with aspects of the individual's "interpersonal competence" (Foote and Cottrell, 1955) or "positive mental health" (Jahoda, 1958), are very troubled by the problem of reality assessment.⁴

In a note on reality-orientation as a criterion of mental health, Jahoda (1958) quotes Wendell Johnson to the effect that "no other fact so unrelentingly shapes and reshapes our lives as this: that reality, in the broadest sense, continuously changes: once we grasp clearly what has been known for centuries and what is, in fact, the central theme of modern science, that no two things are identical and that no one thing is everywhere twice the same, that everywhere is change, flux, we understand that we must live in a world of differences. . . ."

Yet, despite this bothersome statement, Jahoda does include "a perception of reality" as one of the major criteria of mental health because she believes, with Money-Kryle, the English psychoanalyst, that "the neurotic is not only emotionally sick he is cognitively wrong." At this point, however, Jahoda is confronted by the dilemma we have all encountered, namely, that "correctness of perception" "cannot mean that there is one and only one right way of looking at the world around us." Jahoda tries to solve this dilemma by eliminating the concept of "correctness" and replacing it by the criterion of "relative freedom from need distortion . . . a process . . . of viewing the world so that one is able to take in matters one wishes were different without distorting them to fit these wishes. . . ."

Jahoda is, of course, unable to say who will call the "distortions" on whom. It is at this point that various writers have recourse to any one of several "outs" or approaches, which Redlich (1957) has categorized as the "statistical," the "clinical," or the "normative" and Kubie (1954) as the criterion of level of consciousness. Redlich has clearly delineated the limitations of each of these "outs" and concedes that no single approach is satisfactory. The dissatisfaction of these writers seems to grow out of the very essence of the mental idea involving, as Eaton (1951) says, a "relativistic assessment of man's relations to himself, his society and his values."

It is of interest to note that clinicians who see themselves as concerned

⁴ It will be noted that in the above statement, I have used the terms "health" and "competence" interchangeably. I do so in an effort to equate psychological health and "interpersonal competence" in the sense employed by Foote and Cottrell (1955), meaning the functioning of an individual in a social or group world and denoting "capabilities to meet and deal with a changing world to formulate ends, and to meet them . . . utilizing past experience and future aspirations in an effective organization of present effort."

with pathology rather than health seem much less troubled by the intrusion of societal values. The competent clinician apparently feels that he can arrive at an estimate of the quality and extent of pathology without spelling out the social or group situation in which data was collected. I am *not* saying that *all* clinicians proceed in this way, nor that it is desirable to do so, but merely that many competent clinicians can and do. It has been said that a person is just as dead regardless of the social situation which surrounds his inert body. It is much more difficult to make a comparable unchallenged statement about health employing almost any of the current usages. A statement made about an individual's health or competence almost invariably calls forth the question "healthy enough for what?" The "what" generally refers to some aspect of the individual's social milieu.

Perhaps, then, it is because the very idea of health involves some societally derived judgment about the nature of reality that the clinician engaged in mental health work finds the group so useful. The group introduces into the clinical situation a fragment of society or represents a societal microcosm. It provides the clinician with a social context within which the participants, including himself, can engage in reality testing and consensual validation.

Our view, then, is that the small group is a psychosocial entity, capable of delineating its own purposes, boundaries, identity, and relation to both outer environment and its own component units. If one of those units, let us say me, the therapist of the group of delinquent youngsters, disagrees with one of the boy's views of "the good life" as he lives it, and if I insist this represents a "need distortion" on his part and he insists that it is a "need distortion" on mine, it is possible to examine the perceptions, behavior, and feelings of the boy and myself within the context of the group structure of which we are both members. Thus, the group provides a way "to settle the argument," although it is quite possible that no rapid or easy consensus would be achieved. There could be a conflict between the two leaders and their subgroups, between the "gang leader" and the boys who follow him and the therapist leader and his subgroup of "apple polishers." If the conflict in views remained unresolved, we might conceivably introduce some of the other groups to which either the boy or I belong, his gang, his peers who side with me, my staff, or either of our families. Thus, at least theoretically, we could carry the matter further by establishing new "systems of action" formed by the introduction of new participants. In practice, whether any of these groups ever do come together, and under what conditions, will determine in large part which perception of reality, or set of values, or course of action, ultimately does come to prevail.

THE EVALUATION OF INDIVIDUAL AND GROUP COMPETENCE

Let us imagine two parallel systems of the sort described above simultaneously attempting to solve the same problem and coming out with quite different perceptions of reality and different courses of action. Presumably if one followed the sequence over sufficiently long periods of time, it would be possible to make some judgment about the relative competence of the two systems of action in regard to a given specific function even if one never brought the two together. However, since this is often not feasible, the question arises as to whether or not there are any more universal or absolute criteria of group competence. The formulation of such criteria is possible, but only if one is willing to state explicitly the scale of measurement, the purpose, and the task or tasks which we expect the group to perform. Then we can not only measure the relative competence of one group against another but we can study the processes which contribute to it and make predictions of the ultimate outcome. Such criteria of competence may be divided into four general categories: (1) the group's utilization of the individual competence of each of its members, (2) the group's contributions to individual competence, (3) the effectiveness of the group in utilizing or influencing other individuals or small groups outside of its boundaries in the accomplishment of its tasks, (4) the relationship of the interactional functions of the group to the average performance of its members.

These criteria have influenced Roman and Bauman (1960) in their development of the technique of "Interaction Testing." This technique is intended to provide interrelated sets of data about the intellectual and personality characteristics of the group as an entity. Each member of the group is tested individually in the standard manner. Following this the group is tested together, with the instruction that they are to produce one set of responses acceptable to all. The test protocol obtained from the group is scored and interpreted as though it has been obtained from an individual, and test results are based on intensive quantitative and qualitative analysis of the data and comparisons between individual and group performance.

Although this very promising approach has been employed with groups numbering as many as eight persons, it has thus far been used chiefly in the testing of small family groups and much remains to be done in establishing the reliability and validity of the technique. It will indeed be very valuable if it is demonstrated that this approach provides a systematic way of determining if a particular group is more or less likely to improve or impair the functioning of its members.

Various clinicians have attempted other ways of assessing groups in a definitive fashion, but the results have generally been quite disappointing. Unfortunately, it appears that those aspects of a group which lend them-

selves best to precise measurement are, alas, too narrow or circumscribed or refer to a level of function too superficial to interest the clinician. In some ways, it seems as though the relationship between the social psychologist and those interested in groups from a clinical standpoint is comparable to that which used to exist between the psychiatrist and the academic psychologist. One of the contributions of psychoanalysis was to open avenues between experimental psychology and psychiatry. Similarly, we who seek a psychology of groups which is dynamic and capable of encompassing the covert as well as the overt, the latent as well as the manifest, must develop tools to assist us in our efforts to gain access to the emotional, irrational, and the unconscious, as well as to the cognitive, planful conscious processes within the group. But without a conceptual framework, experimental approaches to the group are likely to be sterile and remote from the problems confronting the clinician.

For the most part, those workers who have attempted theoretical formulations regarding the latent aspects of group behavior and "group emotions," as Redl (1955) refers to them, have drawn heavily in the development of their ideas on the psychoanalytic model. One of the most ambitious and useful efforts of this area has been that of Bion (1952). He suggests that every group has two aspects, a "work group" (W), and a "basic assumption group" (B.A.). He believes that the work group has the characteristics of the ego: it meets for a designated task; the character of its participation will reflect its training; it is reality oriented, rational, scientific, and inclined toward cooperation. The basic assumption group, on the other hand, Bion believes to have "instinctive" characteristics, to be inevitable, instantaneous, uncooperative, requiring no training, and essentially independent of time. Certain types of work groups give rise to particular kinds of basic assumption groups and their B.A. leaders. Of course, as time is seen as having no part in basic assumption mentality, there is an "absence of any process of development." Kaplan and Roman (1962), on the other hand, hold that "... all groups, regardless of their purpose or task or nature of membership, pass through specific stages of development and that the work competence and reality testing will vary according to its phase of development."

The crux of the matter as it pertains to group membership and group process phenomena in relation to the development of competence and the maintenance of health is that the professional person engaged in one or another of his activities within the framework of a mental health program may be seen as a work group leader. As the formally appointed leader, he is presumably devoted to some designated purpose. He may be a teacher engaged in assisting a group of educationally retarded youngsters to read, a detached worker trying to convert an antisocial gang into a socially con-

structive group, a child-study specialist meeting with parents of adolescents to help them understand and deal with their children's problems, a family counsellor resolving marital difficulties, a head nurse teaching her staff more effective patient care, or a ward administrator conducting a group of patients and staff to help them solve problems of daily hospital living in order to develop a "therapeutic milieu" or "therapeutic community." Any planful intervention by the designated group leader in any of these situations presumably may involve an attempt to bring about changes in the group as a whole as well as in its individual members. Thus, in approaching any of these group enterprises, we must decide at what level we are going to elicit and attend to data. Will we deal only with conscious, rational, and manifest processes, or the latent, emotional, and irrational as well? Will we look for and try to bring about changes in individual members or the group as a whole? Do we anticipate that changes at these two levels will be related or that they will occur in any particular systematic progression? Finally, we must ask ourselves how we distinguish a group conducted for the stated purpose of maintaining mental health from one which is frankly psychotherapeutic in purpose. Certainly, we ought not attempt to answer this question without a careful examination of the criteria of mental health which workers in the field consider significant.

APPLYING CRITERIA OF MENTAL HEALTH IN THE GROUP SITUATION

A comprehensive summary of the literature pertaining to mental health criteria is contained in Jahoda's *Current Concepts of Positive Mental Health* (1958). She classifies all of the prevailing views under six approaches or "criteria" for positive mental health. These are designated as: (1) attitudes toward the self, (2) growth, development and self-actualization, (3) integration, (4) autonomy, (5) perception of reality, and (6) environmental mastery.

Jahoda limits her presentation to those considerations which pertain to the individual because, "Mental health must be thought of as pertaining to a living organism; it cannot be attributed to any other entity." She acknowledges, however, that, "This is, of course, not to say that the examination of aspects of the situation conducive to mentally healthy or unhealthy behavior is irrelevant. On the contrary it is of greatest importance. . . . In the present context, however, where we are concerned with establishing the premises upon which mental health criteria can be established, the discussion of the situation is superfluous."

Jahoda makes it clear that the kind of "situations" she prefers not to discuss refer to such items as "the German culture" or "totalitarian systems," i.e., situations at the societal or "large group" levels. She apparently does

not consider the possibility of discussing "situation" at the small group level. Certainly, we must grant the author her prerogative when she insists that "the relation of environment to mental health—in other words, *the conditions* under which a person acquires enduring mental health, or will act in a mentally healthy way—must be postponed until the legitimate meaning, if any, of mental health as an attribute of human behavior has been explored."

Two factors encourage us to infringe on the "postponement" that Jahoda suggests. The first grows out of the very structure provided by *Current Concepts of Positive Mental Health*, which does give us a systematic and comprehensive frame of reference; and, second, there is a growing body of knowledge about small group phenomena at a level that pertain to the phenomena of mental health which can be examined within the context of Jahoda's system. These two developments allow us to make a few tentative formulations regarding some interrelationships between Jahoda's criteria and small group phenomena.

It may be well to begin by citing Jahoda's caution that, "To call a situation healthy or unhealthy is nothing but a colloquial ellipsis meaning that it is *conducive* to healthy or unhealthy behavior." In some of the foregoing material in this presentation, we have attempted to demonstrate the significance of the position of the individual who makes a judgment about the health or competence of behavior in relation to the group in which such behavior appears. We have suggested that the very perception of health or lack of health, competence or lack of competence of behavior, will be influenced by the small group situation, and that this very perception or judgment by a member of the small group alters, in itself, the conditions or group situation in which it appears, in accordance with the principles of interaction and homeostasis.

The relevance of the above considerations may be demonstrated by examining Jahoda's first criterion of mental health, "Attitudes toward the Self," or any of the four subcomponents of the criterion which Jahoda designates as (1) Accessibility to Consciousness, (2) Correctness, (3) Feelings about the Self, (4) Sense of Identity.

In a symposium on "The New Member in the Group" (Peck, 1961), I pointed out that "Accessibility of the Self to Consciousness" might be viewed as a criterion relevant both to the competence of the individual and the group. In this presentation, I cited material in which "there were a number of instances in which the functioning of a group or individual was significantly affected by certain crucial information regarding events, feelings, ideas, or impulses which could or could not be acknowledged. The question at times appeared to be whether or not an item consciously experienced by an individual could be openly alluded to in the group, whereas,

in other instances, the readiness of the group to admit, accept, or permit certain kinds of material seemed to determine the emergence of material from preconscious, or even unconscious, levels in the individual."

Clearly, it is difficult to isolate, except for purposes of discussion, "Accessibility of the Self to Consciousness" from "Correctness of the Self-Concept." To a substantial degree the accurate perception of the self must depend on the extent to which thoughts, feelings, and impulses are accessible to consciousness. I (Peck, 1961) pointed out that in our study of intergroup phenomena in a psychiatric hospital, where leadership was autocratic in character, "upper hierarchial groups cannot acknowledge certain interchanges of feeling with lower groups." I cited an instance in which a nurse in the upper hierarchy "may have had to see herself as indifferent to whether or not she was liked by her fellow nurses," and how her wish to have a party to celebrate her entrance into the staff thus became distorted both by her and by the group. Such distortions led to behavior on her part toward staff members lower in the hierarchy which extended the circle of "misunderstanding." I demonstrated how "such processes may assume a cyclical character in which the accessibility of certain materials influences correctness of perception, which in turn influences accessibility, etc. The end-product of such a process will ultimately be reflected in the impaired operation of those members of the staff at the lower echelon who are in most frequent and direct contact with patients. The accuracy and relevance with which they can collect and respond to certain kinds of crucial data about patients will be determined in no small part by the extent to which they have access to aspects of their own thoughts, feelings, and impulses evoked by the patient. This in turn will reflect their experiences in groups in which they have been members previously and in their own peer group within the staff and the nature of its interrelations with the patient group and other staff groups above them in the hierarchy."

If we re-examine the illustration given, perhaps we can discern some of the intimate and complex interrelationships between individual and group competence. Let us begin by trying to delineate rather narrowly just one aspect of competence in a low-echelon member of the hospital staff, a nurse's aide. Let us say that we are interested in improving her ability to provide good care for a patient by helping her to become aware that a particular patient, Mrs. D., wants to feel liked by her even though Mrs. D's behavior is not that which the aide would customarily interpret in such a way. The instance we have in mind was one referred to in a previous report (Peck, 1961) in which the patient, Mrs. D, "expressed seemingly paranoid ideas that she was disliked by the Negro personnel on the ward." This was directed particularly against the aides (many of whom were Negro) and was accompanied by the patient's refusal to eat the food served by them.

Mrs. D's psychiatrist saw in this behavior an infantile demand to be fed and cared for and latent homosexual drives directed at least in part toward the aides, concealed behind a facade of hostile, suspicious behavior.

To assist an aide to view such behavior as being motivated by the patient's "wish to be loved" may be questioned on many grounds. Let us assume for the moment, however, that this is how the patient "really" experienced it and that the aide could be more therapeutically helpful if she was able to make the intuitive jump required to perceive the patient's "true" feelings. The presumption is that this would better enable the aide to induce the patient to take nourishment without engaging in the less desirable alternative of tube feeding, which she had begun to urge on Mrs. D's doctor. Let us agree that the aide's success in inducing the patient to take nourishment involves her professional competence as well as certain of Jahoda's criteria of health, such as "Environmental Mastery" and the "Accurate Perception of Reality." Since we are, for the moment, defining reality in terms of that explanation of what the patient "really feels," which she and the psychiatrist agreed upon in individual psychotherapeutic sessions, perhaps we ought to locate this illustration in that subcategory of "Perception of Reality" which Jahoda calls "Empathy or Social Sensitivity."⁵

Although the criterion of "Perception of Reality" and its subcategory "Empathy" may be the one most applicable to evaluating the aide's competence in this situation, even a limited and oversimplified exploration of the aide's performance within this circumscribed area draws us into a world far more complex than our initial statement of the situation would suggest. These complications may be followed along two lines: (a) any aspect of individual competence, although seemingly most dependent on one or another criterion of health, actually cannot be meaningfully understood, much less improved or maintained, without reference to a number, if not to all, of Jahoda's other criteria; (b) it is difficult to study or influence the factors determining individual competence without understanding and trying to deal with the intra and intergroup context in which it occurs.

In a recent report (Peck, in press), we have described a technique which we employ for gaining access to these group phenomena in a psychiatric day hospital which relieves us of any need to decide which is "sicker," Mrs. D.'s conviction that she is being poisoned or the aide's eagerness to have Mrs. D. tube-fed. In our day hospital, we find it most productive to study and deal with such charges and countercharges within the context of the small group patient-staff meeting where Mrs. D. comes with her "gang"

⁵ Jahoda accepts Foote and Cottrell's (1955) definition of empathy as the "ability to correctly interpret the attitudes and intentions of others, in the accuracy with which they can perceive a situation from others' standpoint, and thus, anticipate and predict their behavior."

of other patients and the aide with her staff "gang," the nurse and psychiatrist attached to this particular patient group. In such a meeting, Mrs. D. is able more directly to express her dependency strivings in a way which *appears* more acceptable to the aide, who, in turn, can respond to them in a way which *seems* more helpful to the patient. In any event, the patient begins to eat, the staff heaves a sigh of relief, and Mrs. D. is on her way to behaving in a fashion more likely to insure her return to the community. This style of behavior may either be referred to as less sick, less paranoid, or more competent and healthier. The aide may be viewed as society's agent in the resocialization of Mrs. D., and the effectiveness of the Mrs. D.-aide dyad may be evaluated by a common societal value or criterion of competence. If the dyad seems to facilitate the performance of individual and group functions, patient and aide may be said to be getting on well or to be a "good combination." If they do "better" within the context of the small group, the group is said to be "a good group."

Let us try to restate the situation in the terms of the individual-group criteria of competence we have been developing in this presentation. If we wish to apply any *one* of Jahoda's criteria to what has happened to Mrs. D., we might say that the essential change "in her" has been a change in her competence with reference to "autonomy." Jahoda summarizes the various defining concepts of autonomy by characterizing it as "a relation between individual and environment with regard to decision making. In this sense autonomy means a conscious discrimination by the individual of environmental factors he wishes to accept or reject." In defining this criterion, which appears to embrace and reflect so many of the factors referred to under the other five criteria, both Jahoda and the authors she cites find themselves playing back and forth between the individual and group or societal frames of reference, just as we did in trying to look at the changes in Mrs. D. and the aide.

For example, Jahoda quotes Riesman's (1950) definition of autonomous persons as those "capable of conforming to the behavioral norms of their society but who remain free to choose whether to conform or not." She also cites Hartmann's (1939) definition as "growing independence from the outside world, insofar as a process of inner regulation replaces the reactions and actions due to fear of the social environment (social anxiety)."

Like these authors, I find that I can no longer refer to that crucial aspect of competence we are calling the autonomy of Mrs. D. without reminding myself that it reflects almost every other one of Jahoda's criteria of health as well as the competence and autonomy of the small group in which it occurs.

Autonomous behavior by an "individual" will reflect the conscious and

unconscious attitudes toward the self developed in the course of an individual's life in the small groups in which he lives. His perception of reality and his ability to master his environment will be determined by the competence with which those groups perform these same functions; and the effective operation of such groups will, in turn, be determined partly by their contributions to the competence of their individual members.

Reality is more unified, more of a piece, than our fragmentary contacts with it suggest. There is a continuous interplay between the integrative and phenomenological levels referred to by such phrases as "self versus other," "perception versus action," and individual versus group.

IMPLICATIONS FOR MENTAL HEALTH PROGRAMS

We may choose for many valid reasons to approach reality or to alter it from any one of a number of vantage points. Workers in the field of mental health who enter through the doorway of a particular small group are continuously reminded that their point of reference may not be identical with that of others. Too, the purpose for which they bring a group together often will not coincide even with the conscious reasons which motivate individual patients, much less with the covert "Basic Assumptions" elicited in the group formative process. The designated (Work) leader may or may not coincide with the Basic Assumption leader; often he will not, in Redl's terminology, be the "central person," or if he is, he may find that the group is inducing or "sucking" him into a role which differs from his preconceived idea of his place in the group's life. The "when" and "how" of the leader's interventions in the group will certainly be influenced by his preconceptions, but no matter how well defined the goals or the program, no matter how admirable the objectives of the leader, unless he is capable of gaining access to and responding to the group process phenomena at levels connoted by the terms "group emotion" and "Basic Assumption," it is unlikely that even the trained leader will contribute very much to the development of individual or group competence.

On the other hand, we are all familiar with those instances in which the covert aspects of the group process, such as a happy coincidence between the group's phase of development and the "intuitive" behavior of a relatively untrained leader, may produce the kind of apparent success which leads us to proclaim the leader as a "natural." Unfortunately, the deficiencies in our knowledge generally prevent us from adequately exploiting such strokes of good fortune. We often do not know how to help the same leader repeat his performance, much less how to transfer what we have learned to another setting or agency. Our inability to generalize from

our success limits us almost as much as our deficiencies in analyzing and learning from our failures.

It is hardly surprising to find the "failures" of the group therapist (or at least his more difficult technical problems) are in similar fields to those which present substantial challenges to all therapists and mental health workers. As a matter of fact, in such fields as delinquency and psychosis, the group therapist is sometimes welcomed with open arms, not because he is thought to be the best man for the job, but because he is the only one who will take a crack at it. This kind of invitation is extended not only to the trained group psychotherapist but sometimes even to someone who is vaguely known to have "worked with groups." The development of generally acknowledged standards for the training of group therapists which is now finally underway will certainly be helpful in guiding the desperate agency in search of a qualified group psychotherapist. It will not, however, be an answer to the question of which agencies, disciplines, and workers currently engaged with groups should be involved in the practice of formal group psychotherapy or in attempting to convert teachers, nurses, or social group workers into group psychotherapists. However, we group psychotherapists can help nonclinical agencies to conduct the groups with which they are engaged in ways which more effectively contribute to the maintenance of mental health and even to the prevention of mental illness.

I do not make this statement lightly. I am quite aware of how few of its promises the mental health movement has fulfilled. Those who followed Clifford Beers vowed that they were going to empty the mental hospitals and prisons. Today, we are somewhat more modest. We ask for, and receive, appropriations on the promise only to reduce hospital admission and readmission rates or the incidence and recidivism rates of juvenile delinquency or whatever. We are fortunate that most appropriating bodies seem to do as inadequate a job of follow-up on the actual impact of our services as we do in administering them.

Yet, I am persuaded that those of us who are engaged in group psychotherapy even in such frustrating areas as delinquency and psychosis can help our communities develop more effective prophylactic approaches to these problems, providing that communities call upon us to engage in prevention. In reviewing my own work history, despite the fact that I think of myself as a public health psychiatrist, I find that I have rarely been called upon by the community to prevent anything. Like most group therapists, I have generally been engaged because the symptoms of some individual or collection of individuals are causing trouble.

When I was a member of the staff of a children's psychiatric service dealing with a great number of childhood schizophrenics, a demand for my services arose because the parents of these children were "uncoopera-

tive" (!) in that they were reluctant, despite individual treatment and/or "persuasion," to sign permission for their children to receive shock treatment or to give their consent for transfer to state hospitals. I (Peck, 1943) have previously reported, as have others who continued the program, how the use of therapy groups not only facilitated parental "cooperation" but apparently managed to do so in a manner which kept some of these children out of state hospitals. In reviewing a few of the lessons derived from that experience, I would like to make some short-hand references to certain of the concepts developed in this presentation.

1. Whatever success we had in this program began with our dealing with the problem not as that of an individual "uncooperative" parent or a schizophrenic child but as that of a child and parent, members of a family group in conflict among themselves and with their neighbors and with the staff over issues involving the extrusion of one of their members, the schizophrenic child.

2. We did not "cure" the parents of an illness in the therapy group. We raised their level of competence as a group by helping the group admit to consciousness such matters as their hostility toward the staff and their guilt toward their children. These kinds of maneuvers do *not* necessarily require the skill of a highly trained group psychotherapist.

3. Changes in attitudes to self led to the parents' more accurate perception of their children within the family group as well as altering their view of their relationship to the staff. This raised their level of competence in dealing with their children and improved their efforts at environmental mastery in dealing with the staff and ultimately with the community. These changes were reflected in a movement toward autonomy in their organization of the League for Emotionally Disturbed Children.⁶ This organization almost single-handedly was responsible for acceleration in the development of private and public school facilities for schizophrenic children. In developing these facilities the parents not only demonstrated their own remarkable competence but raised the competence of their respective family groups which, freed of the burdens of providing 24-hour-a-day care for these very difficult children, could then provide the children with sufficient support to maintain them in the community.

My final illustration is drawn once again from the field of delinquency. Earlier in this presentation I referred to our approach to the youngsters at a court clinic, in which we reconstituted individual delinquents into our own contrived "gang" (or therapy group) and were thus able to initiate the socialization process more effectively than through our individual treatment efforts. I have described the complex alterations in perception of

⁶ This later became the very effective National Organization for Mentally Ill Children, which is now associated with the National Association for Mental Health.

self, other, and reality which transpired in both therapist and boys. In a subsequent experiment, Roman (1957) showed how some of these same techniques could be effectively utilized with adjudicated delinquents who were, as most are, retarded in reading. Because this approach, called "tutorial group therapy," lies somewhere between therapy and education since it centers around the teaching of reading, it might well be carried on in groups conducted by a specially trained and supervised teacher within a school, rather than in a clinic or court setting.

If we follow this line, we move away from the idea of "curing" delinquents of their psychopathology and toward an approach which focuses on raising their level of interpersonal competence in an area crucial to daily living in society. Roman has shown that when we bring about such a change, we not only improve on the usual reading approach but also we may be more effective in reducing both the delinquent behavior and its associated symptoms than when we aim our efforts more directly at the pathology, using more traditional group psychotherapeutic methods.

Delinquents not only live in "society" and in gangs and in classroom groups, they live in family groups, which in turn live in neighborhoods. We have reported (Peck and Bellsmith, 1954) an approach to group treatment of the parents of delinquent youngsters which in many ways was quite similar to that described above for the parents of schizophrenic children. One important difference about the delinquent parents' "uncooperativeness" was that many of them had been refusing to come to the clinic at all, or when they did come, despite obviously disturbed relationships with their children, blamed all of their child's difficulties on a lack of recreational facilities, bad schools, poor housing, racial discrimination, inadequate welfare budgets, etc. Of course, we were suspicious of these "rationalizations" since none of these parents was engaged in any "constructive" effort to deal with these matters—for example, not one of them attended their local P.T.A. group—but we responded to the covert message in their complaints in the way we invited them to the first parent group meeting. "Look," we told them, "we know you think we are not doing you or your children much good. Some other parents have similar complaints against us and we are getting together with them to see what we should do about it." With this kind of invitation, many came, but not to talk about their "psychological" problems.

They took us at our word and kept talking about the bad schools, the inadequate housing, welfare budgets, lack of recreational facilities, etc. It will be recalled that when the therapist was working with youngsters of these parents in a group, he experienced changes in his perception of them reflected in his feeling that as a group, these boys, together, could "take

him" if they wished. So, too, with their parents, the therapist's view that reference to bad schools, poor housing, etc., represented "rationalizations" underwent a similar fate. When six or seven parents are sitting around vehemently proclaiming, almost in unison, "It's the schools," "It's the housing," "It's the welfare," the therapist would have to be of hardy stock indeed to challenge the parents' view or even manage to retain intact pride in his prior perceptions of these parents and the reasons for their "resistance" to treatment. We need not go through the chicken-and-egg question about who changed first, parents or therapist. By now I trust we can agree that the different group situation into which parents and therapist were introduced almost inevitably established a new interactional system with its accompanying changes in perception, behavior, and competence. In this instance these parents, as did the parents of schizophrenic children, ultimately achieved a marked increase in both individual and group competence, which was reflected in their increased participation in community affairs. Here, too, this occurred only *after* the group code changed to allow discussion of and access to feelings of hostility, toward deserting husbands and depriving parents, as well as to guilt in relation to their erring youngsters. Thus, it may be seen that both group and individual changes in the perception of reality were intimately related to improvement in environmental mastery. If this finding is further supported by hard research, we shall have to re-examine some of our traditional concepts regarding the relationships between illness and health, prevention and treatment. We may wish to revise some of the current strategy for the promotion of community mental health, and I suspect that the more effective mental health programs we shall be devising in the next decade will bring the step-child, social action, back into our technical armamentarium.

For some, such a departure may confirm their fears that we have long since left behind our interest in applying the psychoanalytic model to group process phenomena. As a matter of fact, we believe we are just beginning to revive the unfulfilled hopes entertained by Freud (1910) in a paper entitled "The Future Prospects of Psychoanalytic Therapy" in which he optimistically predicted great prophylactic possibilities for psychoanalysis. He states in no uncertain terms that "we expect to gain the authority of the community in general and thus to achieve more far-reaching prophylaxis against neurotic disorders." He says, "Now, in place of a single sick person, put the whole community of persons liable to neuroses, persons ill and persons well, and a little reflection will show you that this substitution cannot alter the result at all. The success which the therapy has with individuals must appear in the many too."

Freud's prediction may be fulfilled, but we must remember that the

principle of Individual-Group Psychological Isomorphism states only that "the psychological organization of groups is fundamentally similar to that of the individual." We do not say it is identical. The processes of change and of "working through" in individual treatment and the roles we have assigned to environmental mastery and social action in our group approach are "similar." However, because the community is not just a complex of intergroup patterns, much less a "collection" of either individuals or small groups, it has its own unique laws and specific level of integration. We are painfully learning to construct bridges between the small group and the individual, and with the collaboration of colleagues in such fields as sociology, anthropology, epidemiology, and community organization, we may be able to complete the span, so that the individual and the groups in which he lives may become part of a healthier, more competent community.

SUMMARY

Some of the relationships between certain theoretical and technical considerations in the group process and mental health fields have been presented. Although substantial bodies of knowledge and practice exist in both fields, too little attention has been directed at the connections between them. This attempt to call attention to these relationships pretends neither to be systematic nor exhaustive. The primary point of departure has been that of the psychoanalytically oriented group psychotherapist confronted with the practical and theoretical problems already visible in our current mental health programs and which promise to become ever more perplexing in the next decade.

Twenty years of personal experience as a group therapist engaged in mental health projects has been critically examined in the light of what seem to be the more pertinent theoretical models. Jahoda's recent review, *Current Concepts of Positive Mental Health*, has been utilized as a base for relating some of our ideas about group phenomena to those of the mental health theorist. An attempt has been made to extend the concept of health, in the sense of competence, from the individual to the group and to improve on our ability to move with more freedom and assurance from the one to the other.

The further resolution of these very substantial conceptual problems will hopefully lead to the development of more effective group techniques in treatment, rehabilitation, and prevention. It may also enable us to achieve a better understanding of the nature of mental health and the processes by which it is maintained and impaired. It is our impression that the small group is an excellent vantage point from which both to study these

phenomena and to intervene in useful fashion, and, thus, that group therapists already engaged in work in the mental health field are in a unique position to contribute to mental health in both theory and practice.

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THE SITUATIONAL PART OF DIAGNOSIS

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In current psychiatric practice, diagnosis means naming the "reaction pattern." For about a decade, the official system of diagnostic classification for psychotic and neurotic illness has been in terms of reaction patterns, and the psychiatric textbooks use the bulk of their pages to describe the varieties of morbid reaction patterns.

In my lifetime in psychiatry, another term, "personality," has also come to play a larger and larger part in psychiatric thinking and discussion. This change has coincided, in time, with the rediscovery of the patient as a person. The patient was never completely lost from view, of course. He always had a prominent role in actual psychiatric work because his name was on the case record and he was the object of some compassionate attention. But, in a significant sense, we can say that the patient has been rediscovered, rediscovered as the person who is reacting to his life-situation in some morbid pattern, which was earlier reified as "the disease." The symptoms and patterns of morbid behavior have become recognizable as meaningful human behavior, as expressions of personality, as modes of response.

Response to what?

In the newer system of conceptualizing diagnostic problems as reaction patterns, this question, "response to what?", logically requires an answer, but we have been slow and somewhat evasive in our attempts to answer it. I would answer it thus: "the reaction pattern is the patient's response to his life-situation." But saying this does not finish the discussion.

There was a time, around the 1920's, when many thought that the morbid reaction was simply the result of a morbid stimulus. It was assumed that the morbid stimulus was some traumatic and unendurable event; but, then, it had also to be assumed that this traumatic event, unendurable in a direct and realistic way, became endurable by some morbid evasion of the reality. Such a qualifying clause obscured somewhat the simple postulate of the psychic trauma as "the cause," that is to say, the simple explanation that the psychic trauma was an event so disruptive or disturbing as to throw the person out of normal self-control and into a senseless exhibition of meaningless symptoms had to be qualified. When we thus invoked the possibility of the psychic dodge to supplement the concept of the psychic trauma, when we invoked the possibility of evasive action or retreat

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to an unrealistic response, we spoiled the neat simplicity of the causation by psychic trauma. The patient was thereby brought back into the picture again as an active agent in the production of his morbid pattern of reaction.

We psychiatrists added this complexity, not out of any love of complexity nor any desire for obscurity, but because it seemed necessary to recognize this complexity in order to gain an understanding of the facts such as would hold out some prospect of dealing with them effectively through some kind of cooperative effort with the patient.

It was in this way, I think, that we came to the pattern of thinking by which many of us now try to get a penetrating understanding—truly a “diagnosis” or “thorough knowing”—of our patients’ problems. We try to discover in what sense the describable reaction pattern is a meaningful response of a describable personality in a describable situation. This triadic formula (Reaction:Personality:Situation) does not solve our problems for us. It merely indicates the general direction or dimensions in which we have come to seek useful enlightenment for designating our patient’s problems and for helping the patient. In other words, our working diagnoses have these three dimensions: we seek to characterize aptly (1) the reaction pattern, (2) the personality, and (3) the situation. When we have aptly stated them, we have therein our working diagnosis.

In this triad, the term about which we are least clear-minded, about which we have the least systematic set of ideas, is the situation.

In recent years there has been a tendency, in certain cases, to put the *primary* diagnostic emphasis upon the situation. During World War II, psychiatry accumulated some new terms, setting this style. Terms like “combat exhaustion” or “operational fatigue” were intended to characterize the outstandingly stressful situation for use as *the* diagnostic label. It made good sense to do so, for many cases could be dealt with promptly and effectively on this simplistic basis. For other cases, for those patients who did not regain effectiveness promptly when treated under the situational diagnostic label, other concepts from the storehouse of psychiatric ideas had to be invoked to establish a more suitable diagnostic categorization.

For another example of the situational type of diagnosis, in recent years much has been written about children with the condition called “school phobia.” In general, however, the term “school phobia” turns out to be an inappropriate catch word, the condition being more accurately characterized as “separation anxiety,” because the more meaningful situational focus is upon the leaving home to go to school.

This example serves to point up the principle that the “situation” is not always what it seems to be.

"APPROPRIATE" AND "INAPPROPRIATE" REACTIONS

Let us consider at this point an apparent paradox in modern psychiatry.

One can make the general statement, with little prospect of contradiction, that psychotic and neurotic reactions are inappropriate reactions, that inappropriateness is their distinguishing general characteristic. The specific items of behavior and feeling constituting the various types of psychotic and neurotic reaction patterns are not inherently and in every instance morbid forms of reaction. Anxiety and dread, for example, are, on appropriate occasions, quite normal and useful feelings. Perfectionism is not always a manifestation of obsessive-compulsive illness; it is sometimes very important to do things just right. So, also, extreme and continuous exertion may be appropriate to certain circumstances. Even idle chatter has its appropriate time and place. But these items of behavior, manifested by the manic patient, appear morbid, and are morbid, because they are done inappropriately.

This proposition, that neurotic and psychotic reactions have the quality of being morbid because they are inappropriate, is one of the most acceptable generalizations in the field of psychiatry. In other words, whenever we make a diagnosis of neurotic or psychotic illness, we make, by implication, a judgment about the situation in that we judge the reaction to be inappropriate to the situation. In most instances we have no great difficulty in making such a judgment. The inappropriateness is so obvious that we do not bother formally to complete our triad of diagnostic dimensions (Reaction:Personality:Situation) by any express attempt to characterize the situation.

Yet, it is precisely on this point that modern dynamic psychiatry makes its most distinctive contribution by disclosing that *these inappropriate forms of reaction are not altogether inappropriate*, that the reaction does have some relevance for the situation as the situation is experienced by the patient.

Situations are not just circumstances. Human beings create situations out of circumstances by bringing to them certain attitudes and expectations.

This is what is meant by an apparent paradox in psychiatric thinking: what seem to be inappropriate circumstances for a patient's pattern of reaction, as seen from the commonsense point of view, may be understood as an appropriate situation when one understands that it is experienced by the patient in a way which for him makes his reaction appropriate.

A middle-aged mother, for example, may have cherished extravagant expectations as to the love and devotion of children toward their parents, and when one of her own children grows up, marries, and moves away,

this mother may experience this situation, not as a fulfillment of hopes, but as a disappointment, even as a desertion, and feel badly mistreated.

Some persons, if laboring under a chronic sense of guilt or if preoccupied by some internal debate between guilt and self-justification, may be inclined to find accusatory meanings in the most innocent remark of some other person, and be precipitated thereby into tearful admissions of guilt, or into resentful counterattacks, or both. Situations so created may be very confusing to the other party.

It is appropriate to note at this point that group psychotherapy has a special value in disclosing and modifying a patient's propensities for the repetitive creation of characteristically unpleasant situations. In a good group session, situations may be produced, and highlighted, in such a way as to focus the patient's attention upon his biased expectations and attitudes, and at the same time the emotional support from fellow patients in the group may make possible the understanding and acceptance of another viewpoint rather more readily than can be accomplished in the one-to-one interview.

The quickness and variety of interpersonal transactions in a well-working group session almost compel the members to recognize the tentativeness and incompleteness of any remark put forth. And in the acknowledgment of tentativeness lies the beginning of wisdom, the germ of the possibility of modifying attitudes and expectations.

This principle of tentativity is extremely important. Whoever would wish to get a working understanding of the human mind must sooner or later come to recognize that the mind is functionally an instrument for tentativity in regard to action. Tentativity is the key concept for understanding mentation. Mental functioning permits imaginative rehearsal and testing of potential action before commitment to behavior. Mental activity of all kinds and at all levels—sensing, feeling, reasoning, fantasizing, decision-making, or whatever special aspect of mental activity one might mention—has functional significance for the better conduct of action through tentativity. Conduct may be wise or foolish, effective or ineffective, conducive to good or evil, according to the use made of the potentiality for tentativity, and thereby the potentiality for modification through experience, real or imaginative.

To state this is not to argue for prolonged deliberation or obsessive review as a prelude to every action. Mental processes can be very fast, and often the prompt impulse is the best guide to action, but not always. Sometimes one stumbles by too quick action; yet one does not need to stumble thus forever. Action is correctible by the actor. Conduct is correctible by the conductor. Expectations can be modified by experience, and behavior

may be more effectively coordinated, sometimes, by holding up action while imaginatively revising one's expectations. Situations may be misapprehended, but one need not go on misapprehending. Expectations and attitudes can be held in abeyance for possible revision by the imaginative exploration and testing that permit situations to be more realistically apprehended for more effective action.

This basic point can perhaps be made clearer by the use of some historical and literary references. In the course of European history, the Renaissance wrought a change, an enlargement, in men's views of human nature and of human potentialities. The Renaissance change of view can be symbolized by the change from the ideological formalism of the medieval morality play to the free-wheeling drama of Shakespeare. The shift in emphasis was away from viewing the meaning and value of life as comprehended by adherence to a religiously prescribed morality and toward a freer and more imaginative exploration of human nature and the human potentialities for unexpectedly splendid or degrading behavior.

The European literature of the post-Renaissance period gives two characters, Shakespeare's Hamlet and Cervantes' Don Quixote, who are exemplars of the two extremes on the tentativity-commitment issue. Hamlet is the example of too much tentativity, a character prone to indecision and vacillation, to too much testing prior to action; and yet this character is presented with a nobility of motivation and a majesty which compels admiration. Don Quixote is at the opposite pole, a character showing such complete and unquestioning commitment to noble sentiments and attitudes as to preclude the practical questioning and practical recognition of incongruous circumstances; and yet this character is presented with such splendor as to win more of the world's affection as a hero than its derision as a fool.

To return to the discussion of the human propensity to create situations out of circumstances in accordance with prior commitments in terms of attitudes and expectations, it requires a considerable degree of sophistication to suspect that a situation, once apprehended in a meaningful pattern, may not be what it seems to be. It requires sophistication, maturity, and courage to question one's attitudes and expectations, i.e., to acknowledge tentativity. Even among psychiatrists, in whom one would presume such sophistication to be well-developed, there are surprising lapses. Tentative guesses, ad hoc hypotheses, when appealingly formulated and expressed, gain quixotic adherents, devoted disciples, dedicated protagonists, to a degree which is astonishing until one takes into account the highly charged emotional character of the milieu in which the psychiatrist works. Faith is a necessity for action in emotionally disturbing situations, and this

necessity for faith tends to fix doctrinaire positions. When we, as psychiatrists, recognize our own tendencies to doctrinaire obsessiveness, we should feel a redoubled compassion regarding our patients and their sticky adherence to the situation as they see it.

PROCEDURES

When one is attempting, as a psychiatrist, to make a reasonably useful diagnosis of a patient's situation, what procedures are available? How does one go about it?

One would like to know the situation as the patient is experiencing it, and also one would like to know the "real situation."

In the situational reactions seen in wartime military psychiatry, the "real situation" usually seemed quite obvious. Prolonged and intensive combat imposed extreme danger to life and limb and extreme physical strains. It posed also extreme psychological stresses: fear of unworthy behavior, fear of cowardice, fear that one might fail to function properly in the team effort. For many soldiers these psychological apprehensions were the worst aspect of the combat situation.

In the ordinary run of civilian psychiatry, the patient's "real situation" in life is often unclear. One may seek to learn about it from the patient's relatives, from work-associates, from other associates and companions, and by using trained social workers to observe, interview, and report "the facts." "Facts are facts," we say, as if that were a guarantee of "reality," forgetting that the very word "fact" means "made," as in artifact or factitious. "The facts in the case" are statements made by some person, and any person, in making any statement, does so in terms of his own preconceptions, biases, and expectations. Often the most important information gained from the informants' "facts" is the unintended disclosure of implied attitudes and expectations relevant to the patient and themselves.

The patient's statements about his situation are similarly informative about his attitudes and expectations. His remarks about his life situation constitute a kind of screen upon which he projects himself.

As a teacher for many years I have geared my teaching to patients' problems, interviewing patients in the presence of others, and in that setting there is an additional value in using the situational approach because the patient is somewhat less embarrassed about his reactions, and therefore he usually speaks more revealingly. I should add, in regard to such didactic interviews, that I have made it my purpose on every occasion to make the interview of value to the patient, an actual opportunity to talk about his or her concerns. When one is successful in this purpose, word gets about among the patients, a cooperative attitude is established, and new patients,

being favorably influenced by this prevailing attitude, come eagerly if somewhat anxiously to talk things over. Without such a favorable attitude among the patients, this custom of didactic interviews cannot be maintained in an institution at the appropriate level of earnest and honest interaction.

There is, however, a troublesome by-product of the situational approach in such educational interviews in that new students are likely to jump to the conclusion that I, as interviewer, stress the situation because I think that the situation "stresses" the patient and is therefore the *cause* of the patient's illness. In the teaching situation, one has to supplement and interpret such situationally oriented interviews with carefully reiterated emphasis upon *all* the three points of the diagnostic triad (Reaction:Personality:Situation), and it is also wise to review in every case discussion any available evidence of organic lesions or toxic or debilitating conditions in order to help the student to gain, and to maintain, a reasonably comprehensive perspective upon the patient's problems and upon his current mode of coping with them or of evading them.

SYSTEMATICS

The situational part of diagnosis would be advanced in a systematic and practical way if we had readily available for common clinical use a convenient list of a moderate number of clearly defined classes of situations, but it is a difficult field to categorize. It is hard to delineate distinct types of situations having clear relevance for the clearly recognized reaction patterns. The crude materials are presented by patients and others with great circumstantiality and prolixity.

But then, of course, we have to recognize, as a matter of fact, that the reaction patterns are not in actual life quite so clearly distinct from each other as the textbooks would make it appear. In current diagnostic practice, with the emphasis primarily upon typing the reaction pattern, diagnostic agreement is not at a very high percentage level—between thirty to fifty per cent agreement, according to different reports. In part, these somewhat discouraging figures reflect the inadequacy of one-term diagnostic classification. It is my impression that the expression of diagnostic formulations in the triad form (Reaction:Personality:Situation) provides a more meaningful basis for diagnostic agreement among different psychiatrists. I think that in many instances of disagreement in one-term diagnoses, there may be very considerable agreement in the understanding of a patient's problem and reaction, this measure of agreement being concealed or obscured by stylistic differences in the choice of labels. I cannot document that impres-

sion by statistical studies, and I may be mistaken, but I should like to emphasize the advantage of achieving a concise, widely acceptable list of a moderate number of situational characterizations. The difficulty in achieving this desirable goal arises in part from the great cloud of circumstances in any particular situation and in part from uncertainty as to the issues which make the situation meaningful. And the difficulty is also compounded by professional bias. Circumstances are considered objective, issues subjective; and the general scientific bias favoring objectivity tends to direct attention toward circumstances. In my opinion, life situations are more significantly grasped in terms of the issues which express conflicting attitudes and expectations than by any scheme for constructing mosaics or constellations of circumstances; but I must admit that it is easier to observe circumstances than to discern issues.

For the purpose of discerning issues characterizing life situations, there is much practical advantage in accepting and making use of the well-recognized steps in a life career: for example, courtship, marriage, parenthood; getting a job and holding a job; having to take orders or to give orders or to make responsible decisions; change in status or prestige; retirement and old-age dependency. Such situations may be outlined in apparently objective terms, but their dynamic significance derives from individualistic considerations of pride, honor, vanity, and shame; of affection, devotion, respect, and resentment; and there is always a background of culturally conditioned special meanings and values.

In trying to size up a life situation, it is important to keep in mind that one often encounters a patient who has not developed the maturity of personality which one might expect for his age. His sense of well-being and security may be dependent upon preserving a social context for his life suited to his level of immaturity. I am not saying that this is as it should be, nor that others owe him the obligation to maintain, unquestioningly, the supports suitable to his immaturity. What I am saying is simply that such situations exist and need to be recognized and understood.

Having struggled for some years with the pedagogical problem of a teachable systematization of situations, I must still confess dissatisfaction. I have no satisfactory over-all classification of life situations, comprehensive for all ages and all circumstances. I do have, however, a simple three-item schematization which I have found to be a useful guide in many cases. It is as follows:

1. The adult person in his working years is considered as having committed himself more or less definitely, outwardly and inwardly, to certain responsibilities and values. He is concerned to live up to these value commitments, and his life situations are shaped by the issues arising from such

commitments. His anxieties and depressions, his heroic or evasive efforts to cope with life, have meaning in terms of these commitments. His life situations are characterizable by his need to fulfill his commitments and by his attitudes concerning them.

2. The life situation, for the person of declining years, poses the problem of withdrawing from commitments, of retiring from a job, of finding less energetic means of maintaining a sense of personal worth and significant function.

3. In the younger period of life, particularly in adolescence, the life situation involves the choice of commitment. What values is one to recognize and make one's own? Out of the varied and conflicting expectations, ambitions, and aversions arising in adolescence, or pressed upon one then, what can be accepted, or forged for oneself, with a dignifying sense of personal integrity? I recognize that there are many adolescents who quietly adopt prevailing value commitments and who move into the adult stream of life with little if any evidence of doubt or confusion. Perhaps they are the fortunate ones. At least one may say with some assurance that such a smooth progression into the age of commitment and responsibility argues well for stability and normality in the conventional mode. But there are many others who present themselves as psychiatric patients in the adolescent years, or in the retarded adolescence of later years, because they are struggling confusedly with uncertainties about values and about their personal commitment to values. Much that is bizarre and apparently inscrutable in the schizophrenic types of reaction, for example, becomes understandable in the frame of reference provided by this view of the adolescent life situation. In later periods of life, if one feels oppressed by a sense of inadequacy to one's commitments, doubts may be generated as to those commitments and the life situation can be transformed from the issue of personal adequacy to a more disconcerting questioning of values.

These three ways of categorizing life situations have been useful in my experience in a large proportion of cases, and I can earnestly recommend them, so far as they go. They can be succinctly restated thus: the *Adolescent Type of Life Situation* is characterized by uncertainty as to one's commitments and doubts as to the values and meanings of life; the *Responsibility Type of Life Situation* is characterized by issues as to personal adequacy and self-justification in reference to commitments clearly established; and the *Retirement Type of Life Situation* is characterized by the necessity to retire from commitments when changing circumstances or receding opportunities or declining energies demand such readjustment.

CONCLUSIONS

At this time in the development of psychiatric practice, we are rapidly moving in the direction of a larger and larger involvement in extramural operations, i.e., in community psychiatry. This means, among other things, that all psychiatrists must envisage their patients' problems in their natural habitat, so to speak, in the circumstances of family life, job, and recreation, rather than in the somewhat artificial and unnatural circumstances of institutional living. It becomes all the more necessary, therefore, for psychiatry in our time to seek systematically for penetrating understanding of patients' life situations. For this purpose, one needs not merely a factual knowledge of detailed circumstances but a comprehending grasp of the issues and forms characterizing life situations as experienced by patients, as well as an awareness of the human potentialities for tentativity and commitment.

Logical clarity requires that when we designate a patient's reaction pattern, we indicate in some way what we understand his reaction is about. But logical necessity is not the most important consideration here. Situational insight is needed, *primarily*, in order to increase our usefulness to patients in coping with their life situations.

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GROUP THERAPY IN A WORK ADJUSTMENT CENTER

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An important factor contributing to failure in job placement appears to be the presence of severe emotional disturbance. The rationale behind the present study was that if the emotional factors contributing to unemployment were worked with more directly, the chances for vocational success would be increased. Because of favorable reports in the literature by Ends (1959) and Fairweather *et al.* (1960), it was decided to institute an experimental group therapy program as an integral part of the workshop process in a work adjustment center. It was felt that intensive group psychotherapy would have the best chance of effecting, in a positive way, during the fixed twelve-week period of time, the variables measured in this study: intellectual functioning, attitudes, manual performance, and personality factors. Rapaport (1946) has found that anxiety tends to interfere with manual performance and cognition. Therefore, it was hypothesized that participation in group psychotherapy would result in a reduction of anxiety significant enough to reflect improvement in both areas.

The main hypothesis was that the addition of group therapy to a planned vocational experience of twelve-weeks' duration would more favorably affect the above-mentioned variables than would the work experience alone. It was decided to test this hypothesis by studying two groups of Center clients. Each group contained sixteen subjects. The selection of subjects was made randomly from the incoming population of the Work Adjustment Center. All of the subjects were males between the ages of 16 and 55; all were considered unemployable when entering the workshop program. One group participated in group therapy sessions three times weekly over the twelve-week process. The other group was not involved in group psychotherapy during the twelve-week period. Both groups participated in the usual work adjustment process as described by Reiser and Waldman (1961):

The program tries to provide optimal conditions so that each client can use progressively more of his inner potentials and so effect a heightened awareness of his basic adequacy as a worker. Such factors as work tolerance and interpersonal relationships are considered most important.

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The Center accepts persons who are considered unemployable, regardless of race or religion, and works with them for approximately twelve weeks in attempting to make them employable. Clients are referred from many sources, such as the State Bureau of Rehabilitation, State Counsel for the Blind, Veterans Administration, schools, psychiatric hospitals, and other agencies.

The program is divided into three main phases. During the first two weeks the clients are placed in the diagnostic section. Here they are assigned simulated work tasks which are separated into 12 industrial categories, and further subdivided into five levels of difficulty. The first level consists of simple repetitive tasks not requiring initiative or abstraction. The tasks become progressively more complex, those at level five requiring conceptualization as well as fine dexterity and visual motor coordination. The performance of these tasks provides indices of speed, quality, comprehension, fine and gross dexterity, motivation, etc. In addition to evaluating these factors, the psychologist in the diagnostic section makes daily observations in the areas of attitudes toward self, work, co-workers, and supervisors. These observations then enable the psychologist to write a summary report which includes recommendations for guiding the client in the next phase, as well as other suggestions felt to be desirable in facilitating maximum rehabilitation of the client. The general atmosphere of the two-week diagnostic phase is permissive and supportive, and this atmosphere is carried over into the next phase of the program.

After the diagnostic phase, the client is transferred to a production setting and put on the payroll. Here he performs routine, factory-type work the Center obtains on contract from local companies. The type work the Center obtains on contract from local companies. The production foreman is a psychologist who takes the role of work supervisor while continuing the evaluation process. He makes written observations daily and completes rating scales as well as objective reports. Although the first few weeks in the production setting are also permissive and supportive, the supervisors soon begin to increase structuring and setting work limits for the client, in order gradually to approach a reality situation comparable to what will be encountered in a competitive job. (Clients are not trained for any specific job; rather, the goal is better utilization of remaining potential and acceptance of limitations.) During this process of introducing more reality testing, the foreman purposely alters his role toward the client in order to test his limits of reactivity as well as to condition the client to being less defensive in certain sensitive areas.

At the end of approximately eight weeks the client enters the third phase of the program. The third phase conforms as closely as possible to an actual work situation. Here the client works relatively independently, with a minimum of supervision and a maximum of responsibility. This is the phase before placement activities are initiated for the client.

In the placement phase, the client is assisted by a vocational counselor in the activities related to job-seeking. These activities include personal appearance and deportment, interview behavior, application procedures, and specific techniques for locating and securing employment. However, since the placement process is stressful, the transition from the work adjustment program to competitive employment is made gradually. The client continues to work in the Center but goes out one or two days each week on supervised job-seeking activity. Since the placement process is usually a difficult and threatening period for the client, the vocational counselor also provides support and guidance.

After random assignment of subjects to the two groups had been completed, it was found that the groups were very similar in regard to age, educational level, and diagnostic category. Some of the men had been repeatedly fired from jobs, some continually quit because of unrealistic dissatisfactions, and a few were incapable of securing jobs subsequent to long periods of hospitalization in a mental institution. All of these men were considered currently unemployable for reasons of emotional maladjustment. Physical disabilities were not a prime factor. In order to describe the emotional status of subjects in each group, every client was placed in one of five commonly used diagnostic categories subsequent to assignment to either the therapy or nontherapy group. For purposes of consistency, all clients were placed in a diagnostic category using the following criteria:

Psychotic (in remission): History of hospitalization for psychotic behavior or medical diagnosis as psychotic.

Neurotic: Either presence of functional difficulties which severely limit functioning but no history of hospitalization for psychotic behavior, or medical diagnosis of neurosis.

Organic brain damage: Medical evidence of organic brain damage.

Retarded: Full scale I.Q. below 80 on the Wechsler Adult Intelligence Scale and absence of functional or organic involvement as a causative factor.

Character disorder: Antisocial behavior and history of involvement with law-enforcement authorities.

It was recognized that in classifying individuals as to diagnostic categories, symptoms in several categories may be present. However, the determining factor used was the problem considered the greatest deterrent to employability.

The Wechsler (1958) Adult-Intelligence Scale was used to measure changes in intellectual functioning. The Osgood (1957) Semantic Differential was used to evaluate change in attitudes toward self, co-workers, supervisors, and work. Manual performance was measured by the Crawford

(1956) Small-Parts Test and the Minnesota Rate of Manipulation Test (Ziegler, 1957). The personality factors id, ego, and superego were assessed by the Sixteen Personality Factor Questionnaire (Cattell, 1957). The independent criterion for evaluating the difference between groups in regard to employability was that of sustained employment for six months following completion of the process.

Before beginning the work adjustment program, the client was given all of the tests listed above, along with other tests which were used for concomitant research purposes. The tests were administered at two sittings on two consecutive days, each of the two testing periods requiring about two hours. It was routinely explained to each client that the testing procedure was a standard part of the individual's Work Adjustment Center process. The test battery was administered to each client individually and was always given in the same order and with the same instructions. Following completion of the initial test battery, the client began the twelve-week adjustment program. A post-test battery was administered immediately after the client had completed the twelve-week program. The same examiner administered the pre- and post-tests to each client. Subjects of both the therapy and nontherapy groups were exposed to the same workshop program. The program consisted of two weeks of diagnostic evaluation, two weeks of production evaluation, and eight weeks of work adjustment training. The clients worked six hours a day, five days a week during this twelve-week period. The only difference between the two groups was that members of the therapy group attended group-therapy sessions for one hour, three times weekly, at the end of the work day.

The therapy group was open-ended. Each of the sixteen individuals was exposed to exactly 36 group therapy sessions over a twelve-week period. However, at any one time there were approximately eight clients in the therapy group. Incoming clients were placed randomly in the therapy or the nontherapy group. The only deciding factor used other than random placement was that of adding people to the therapy group as needed to maintain an optimum number in the group. Personal characteristics were never the deciding factor, and new members were simply added to the group as old members completed the program. Group members had been orientated beforehand that they were randomly selected to attend the group therapy sessions and that the group therapy was considered a necessary part of their program at the Work Adjustment Center. Attendance was considered mandatory. Two staff psychologists were present at each group therapy session, one acting as group leader, the other as observer-recorder. Each psychologist spent approximately half of the total time as group leader and half as recorder.

Group psychotherapy, as practiced in this research, had a group-

centered approach in which decisions and responsibilities were left ultimately to the group members. The group therapist functioned mainly as a stimulus figure who might also clarify, focus-on, review, and connect various emotional and verbal components of the group process. However, occasional role-playing and "going around" were included. The last five minutes of each group session were used by the recorder to read back to the group an objective resumé of main themes and topics discussed during the session. In addition, one entire session per week was tape-recorded with the full knowledge of all of the group members. A ten-minute portion of this tape was played back to the group at the beginning of the next session for purposes of introducing objectivity and reality testing. The tapes were also used by the two psychologists for evaluation of therapist and client behavior. At the end of the twelve-week program, each subject was retested by the same examiner with the same battery of tests given initially.

Statistical results of tests-retests between the therapy and nontherapy groups showed no significant differences on the WAIS for the variable of intellectual functioning. There were no significant differences between groups on the variable of attitudes toward self, co-worker, supervisor, and work, as measured by the Osgood Semantic Differential. Results of test data for the variable, personality factors, as measured by the Sixteen Personality Factor Questionnaire, showed a difference in favor of the therapy group on Factor C (ego strength) significant at the .01 per cent level. Factors G (sugerego) and C-4 (id) were not significantly different. On the variable, manual performance, as measured by the Minnesota Rate of Manipulation Test and the Crawford Small-Parts Dexterity Test, results were generally not significant, with the exception of the Screwdriver Subtest of the Crawford, which indicated significant improvement in fine dexterity for the therapy group at the .05 per cent level of significance.

That the therapy group showed greater improvement on the Screwdriver Subtest than did the nontherapy group is attributed to the hypothesis initially presented that a reduction in anxiety would contribute to improved manual performance. It is not exactly understood why there was not parallel improvement in the other manual performance tests. Perhaps the nature of the different tasks was responsible. The Screwdriver Subtest merely requires turning a small screw into a metal plate with a small screwdriver. Only one continuous step is involved and consequently a change in set is not required of the client during this process. The other Crawford item, the Tweezers Subtest, requires the client to insert small pins into the holes in a metal plate and then place collars over these pins using a tweezer for each of the two steps. In this operation a slight change in set is required, an additional step is involved, and two differently shaped objects are being

manipulated. Thus, the differences between the processes involved in the two subtests, the nature and variety of materials used, and the change of set required in one subtest and not in the other, may have been deciding factors in differentiating the two groups rather than "fine dexterity" alone. Dynamically, the use of tweezers may be viewed as requiring inhibition of aggression, whereas the Screwdriver Subtest may allow aggression to be expressed more directly. On this basis, the improvement of the therapy group on the Screwdriver Subtest at the .05 level suggests improvement in being aggressive.

The Minnesota Rate of Manipulation Test requires the client to place cylindrical blocks, all of the same size, in holes in a board, using both hands and picking up and placing one block at a time with each hand simultaneously. The holes are arranged four in a row with a total of sixty holes. Four trials are required in this test. At the end of each trial, an abrupt change in set is necessary which requires the client to remember to pick up a different configuration of blocks. Much fumbling was noted when these set changes took place both during the client's initial and terminal performances. The abrupt change in each of only four trials probably did not give sufficient practice for a set to become established, and may have been the factor contaminating the performance of both groups.

Since Factor C (ego strength) of the Sixteen Personality Factor Test was the only one of the personality variables to show significant change, it may be of interest to know what some of the dimensions of this trait are. Factor C, ego strength, on the test, had the following factor load: emotionally mature versus lacking in frustration tolerance; emotionally stable versus changeable; attitudes calm and phlegmatic versus showing general emotionality; realistic about life versus evasiveness; absence of neurotic fatigue versus neurotically fatigued; placid versus worrying (Cattell, 1957).

Subjective observations of clients in both groups seemed to indicate that members of the therapy group developed more verbal coherence, better reality testing, improved physical appearance, lessened anxiety, less fear of loss of emotional control, greater expressiveness, and improved interpersonal relationships. It was noticed that the process of integration began toward the end of the group therapy program seemed to continue after the client left the Work Adjustment Center. This was reported by placement counselors, family members, the clients themselves, and by staff when the client visited the Center. These improvements are attributed to the combined program. Although it is possible that some differences were present between the groups initially, it is felt that the use of a random selection technique minimized this chance. The two groups were compared on initial test results to determine if any significant differences existed at the start.

These comparisons indicated that statistically significant differences did not exist at the start for any of the criterion measures.³

The independent criterion for measuring the effectiveness of the group therapy process was immediate placeability in employment and stability of employment over a six-month period for the two groups. Results on immediate placeability were: 69 per cent (11 clients) placed of the therapy group, and 44 per cent (7 clients) placed of the nontherapy group. At the end of a six-month period, 75 per cent (12 clients) of the therapy group were employed, as compared to 44 per cent (7 clients) of the nontherapy group. Using a chi-square for two independent samples to measure the significance of differences between the raw N's, the following results were found: for immediate placement the therapy group exceeded the nontherapy group at a .15 level of confidence; for stability of employment over a six-month period, the therapy group exceeded the nontherapy group at the .08 level of confidence. That these results show only a trend is obvious, nor can much be made of a single additional job placement in the therapy group as opposed to the nontherapy group during the six-month follow-up period.

The factors that seem to indicate a change as a consequence of group psychotherapy, in addition to the possible effects on motor performance, are the subjective observations of general improvements noted above and the parallel improvement on the ego-strength factor on the Sixteen Personality Factor test. The significant improvement on the ego-strength factor, the subjective observations of daily functioning, and the improvement in the motor area, all suggest that the combination of group therapy and the work adjustment program had a greater effect on client manual performance and ego strength than did the work adjustment program alone. Of course, there is the possibility that these measured improvements were due to chance, since, out of 26 tests, at least one may be expected to reach an acceptable level of significance.

There are several possible reasons for both groups not improving significantly on all of the variables investigated. First, it is possible, though not likely, that the test changes noted were a result of chance. Second, the relatively short time period of twelve weeks might not have allowed improvements in these variables to reach the level of statistical significance. Third, it is possible that the units of the measuring instruments were too gross to detect certain changes occurring in process. Also, there is a good

³ It would have been of interest to compare initial testing of the drop-out population (N=7) with that of the population that completed the program, since there is evidence in the literature that those who drop out of group therapy differ in many respects from those who remain. However, the test data for the drop-out population is not available.

possibility that these limitations are reflected in only a slight trend being indicated by the independent criterion of employability.

One may conclude from these results that for many individuals whose emotional problems are not too limiting, the work adjustment process alone may be enough to increase the chance of employability. However, people who are more deeply disturbed may require an approach which will be more effective. This will take a longer period of therapy. Jaques (1960) has remarked that since work is essentially an ego function, a modicum of ego resources is required in order to accomplish work satisfactorily. It would seem that group therapy within a work program is a promising means of modifying ego functioning in a positive direction. However, much more work needs to be done in this area.

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THERAPEUTIC GROUPS OUTSIDE A PRISON

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An earlier article (Taylor, 1961) emphasized some of the approaches in group psychotherapy that must be modified to suit both the therapeutic situation and the patients with whom the therapist is working. In the instance of a therapist dealing with a prison population, some understanding of, and adaptation to, the cultural, social, and psychological forces that operate within the prison (Taylor, 1962a) are essential if the therapeutic group is to be helpful, or even viable.

Prison is an artificial environment, and while the walls reinforce the neurotic drives for security of some men, they are a constant mockery to others (Taylor, 1960). In prison the opportunity for social and physical adjustment between the sexes is lacking. Prisons also severely limit responsibility in daily affairs and in family affairs, allowing little scope for showing interest, ambition, drive, or personal worth. There is no changing scene to relieve monotony and give practice in human relationships. As far as therapy is concerned, prisoners are frequently unwilling subjects, few of them having previously shown any awareness of emotional or social disorder by seeking treatment before coming to prison.

Initially, the therapist has, by his manner, reasoning, and approach, to state his case for psychotherapy without being too optimistic and without holding out promise of cure. He must acknowledge the drawbacks of prisoners having little or no choice of therapist and of the fact that they cannot be promised anonymity in treatment because of the closed prison community. However, despite these obstacles, group therapy in a prison setting can be effective (Taylor, 1961), and there are indications that a continuity of treatment when offenders are released from prison is worthwhile.

THE EX-PRISONER

The fresh air of freedom and the bombardment of experiences and obligations that released prisoners receive as they attempt to adjust to the pace of life outside can be both exhilarating and overwhelming. Ex-prisoners display paranoid symptoms that are to some extent imaginary, but to some extent reflect the attitude of a number of people in society. To overcome these feelings the ex-prisoner must either be frank and cut his losses when he is rejected, or else he must manufacture stories that are adequate to cover the gap in his life occasioned by imprisonment. Should he tell his

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boss that he has been in prison before the boss engages him or afterwards? Should he tell his girl friend? If he delays the story, how much effort will be required to control the fear of being found out? Delicate situations constantly arise. One parolee was directed by his employer to act as store detective and bank messenger; the stress was great not only because of the responsibility of the position of trust but because he had not told his employer that he had just been released from prison. Another was acting as a baby-sitter, and when the parents returned from the movies, they discussed a case of rape that had been dramatically portrayed, and he wondered how well he could conceal his own feelings at having experienced an almost identical emotional situation as the principal character. Another had difficulty in getting used to realizing obligations to his employer. He was sick and was dismissed for not notifying his employer that he was not coming to work. He did not realize that his employer depended on him and that he was expected to show some sense of responsibility. Another was disturbed by legitimate police inquiries on his first day at work when his description fitted someone who had stolen money from a nearby shop. It was also a fresh experience for these parolees to meet prison officers on equal terms in the street, and they found themselves looking upon them in quite a different light. They were surprised at the friendly nods and greetings they received from officers who were off duty and out shopping with their families, and as a result they began to re-examine their prejudices about prison staff.

Men leave prison, too, with a fear of relapse in the back of their minds. Outwardly, they may express confidence in not coming back, but underneath is the knowledge that subsequent offenses are seen in the light of previous convictions, and having been imprisoned once will most certainly lead to heavier penalties next time. In this sense, prisoners feel that they never pay for their crimes. Such feelings, however, gradually diminish as the months pass after discharge from prison, and they may fade completely as the ex-prisoner becomes a fully competent citizen.

Problems of freedom when released can only be anticipated by the "first admission" in prison. They are revived as painful experiences of failure by the recidivist, and when the man is released, he must look at old problems again. If the man has been in treatment while in prison, he may look at the problems afresh, or he may have changed enough to be looking as a new person at old problems. One ex-prisoner remarked that he was having trouble with his conscience, whereas previously he would have taken advantage of every opportunity for sexually promiscuous behavior without the slightest concern. He also found himself reacting against hooligans who swore in the presence of women. Others on release may experience loneliness, rejection, and derision from members of their family and

gangs who only knew them as they were before and are puzzled at the change. On release, men may not be strong enough to stay away from previous associations and hold firm to their newly found standards. This is perhaps the greatest struggle that takes place during the critical few weeks after release. If they have had experience of a group, and there is a group operating outside a prison, they may get mutual strength and encouragement to avoid slipping back to the old ways. A therapeutic group in prison can fill vital needs of emotional security and personal worth. Indeed, this may become so important that the sanctuary of the group may be an unconscious factor in causing discharged men to return to crime. This may suggest that the therapist did not succeed in bringing about the intended goals of independence and psychological maturity in his patients, but this may not be entirely the therapist's fault. The unreality of the prison, as suggested earlier, and the cessation of treatment at the legal expiration of the sentence, are factors beyond the therapist's control. Theoretically, an indeterminate sentence would meet the objective of timing release from prison with psychological maturity—in analogy with patients discharged from mental hospitals—but indeterminate sentences can cause uncertainty, unintended manipulation of hope, and despair if "knock-backs" are received from the parole board. Thus, swings of mood can negate any positive factors that might otherwise recommend indeterminate sentences (Taylor, 1962b).

CONTINUATION OF GROUP THERAPY AFTER DISCHARGE

Continuity of treatment outside prison seems a better approach for men whose emotional problems are only partially resolved at the time of prison discharge and for whom problems of living in a free community arise. The suggestion of a continuation of group therapy after discharge originally came from a therapeutic group inside a prison consisting of men with marked character disorders. The suggestion remained in abeyance for nearly two years. By this time, four ex-members of the prison group were residing in Wellington—others had been released but were living in other parts of the country—and the four were prepared to become the nucleus of an experimental outside group. They had been out of prison for varying periods. Each had had approximately eighteen months' experience in the inside group. Their ages ranged from 25 to 37, their combined sentences totaled thirteen years, and their offenses included breaking and entering, theft, escaping, and rape. None had ever previously reached the end of a probation period without committing a further offense.

Great interest was expressed in the outside group by those in the inside group, and they were keen to exchange tape-recordings of sessions

with the outside group in order, as one member said, "to get some reality inside the jail." For their part, those outside were also eager to exchange tape-recordings to serve as a reminder of the possible consequences of further offending, perhaps a self-imposed therapeutic deterrence. The inside group also valued the development because it gave them promise of support at the time of their own release.

It was decided that organization would be kept to a minimum, that there would be no formal structure to the meetings, and that they would be held one night a week from eight until ten o'clock on neutral territory. The members felt that they should be quite independent of law-enforcement agencies and that the voluntary nature of the group should be emphasized by its having only the slightest formal attachment to the Justice Department through the therapist. The Society of Friends in Wellington made available a place for the meetings, and the Secretary for Justice approved the formation of the group, which was necessary because ordinarily the men were forbidden to consort with others with a criminal record. The members were parolees with legal obligations to the local district probation officers. As a matter of courtesy the psychologist discussed the formation of the group with the probation officers and obtained the same goodwill and co-operation that prison officers had given the inside group. The outside group was not seen as an attempt to displace probation officers but, instead, as an attempt to deal with emotional conflict rather than social conflict.

The inside group had operated successfully on three rules. The first was that recruitment was to be made through the group itself and that members were free to leave at any time provided they discussed their reasons for withdrawing with the psychologist. Secondly, the content of group meetings was to be regarded as confidential. Thirdly, the group was designed to encourage inmates to talk about emotional problems rather than to serve as a debating club or current affairs group. These three rules had operated successfully with the prison group over a two and a half year period, and it was thought that they might serve as a basis for the continuation of the group outside. The implications of the organization were that there could be no direct referrals from agencies and that no information could be obtained about members from the psychologist. Membership in the group could not be made a condition of probation or parole because the members were to be free to leave as and when they desired. The group outside prison would operate quite independently of authority, but the group would encourage and expect its members to fulfill the obligations set by the parole board and the probation officer. In return, the group expected the probation officer not to regard group attendance as a substitute for reporting.

The principle was that if reporting to the probation officer could be relaxed, it should be done for reasons other than the parolee being a member of the outside therapeutic group.

The group wished to begin as a small unit, gradually recruiting up to the stage of being ten in number, this number having proved to be the optimum number with the inside group. The key to recruitment would be the *need* of potential members; it was not a requirement that they should have been a member of the inside group or that they should have been to prison. It was felt that possibly there were probationers whose conduct was "norm violating" but who had successfully evaded the law who might profit from joining the group. Possibly the group at some stage might expand to include females with behavior disorders and emotional conflict.

In the early stages the therapist was required to intervene in a different way from that necessary with the inside group. Within prison, tension had to be dissipated toward the end of a session to prevent igniting the anxiety that is permanently found in a dispirited and embittered prison population. Outside prison, uncontrolled negative feelings, it was felt, could lead to the creation of a criminal gang. For this reason the therapist needed to make sharper observations in restoring the balance of reality than was necessary with the group inside prison. The dangers of gang activity were a factor in the therapist's belief that a small group was preferable to a larger group. Another persuasive reason was that participation for individuals in larger groups is less direct, more reflective and passive, than in smaller groups, and criminals with character disorders are rarely passive and reflective.

Four months after its initiation, the group as such was nonexistent in the sense that there were no regular meetings each week. However, the members all approached the psychologist individually to discuss different aspects of their social and psychological adjustment to the free world and at the same time they continued to express interest in the group as a whole. Without exception, they said that they wanted the group to remain intact; and it must be remembered that the speakers were not in the habit of saying one thing while desiring another. They did not, however, keep up their group membership for a number of reasons. To begin with, there were many counterattractions and spontaneous relationships and associations in their everyday lives that they had not experienced as prisoners, and they took advantage of the opportunity to indulge themselves in stimulating activity. Many of them also took on responsibilities, either by working late or by other undertakings, which made it difficult for them to leave one night free to attend the group. One could make the assumption that the group dwindled because there was no need for it to exist. In fact, the need did

exist but it was somewhat different from the need that had existed while the men were in prison. What the members finally wanted was the availability of the group should their problems become of such a nature that they had to forego other activities in order to deal with them.

Exactly the same pattern was followed by a second group established six months later. Again, the group was formed at the request of those who had been members inside prison. The same informal organization was adopted as before, and once again the attendance dwindled.

The fact remains, however, that only one of the eight recidivists who elected to join the groups committed further criminal offenses, and he was a man of 45 who had spent as much of his life in prison as outside. The other seven are still clear of the criminal law, and from occasional contacts it is clear that they are leading acceptable lives quite different from what one would expect from a study of their histories or prediction tables. The four members of the first group have been out of trouble for two and a half years, and for three of them it is the first time since the age of 15 that they have been under no form of statutory authority. The three survivors of the second group have been at liberty for nearly a year, but the one defaulter lasted only a few days outside prison.

CONCLUSIONS

Experience of this kind leads one to examine the case for groups outside prison. The members had expressed a desire for outside groups, and from the results they appear to be of value in rehabilitating criminals. The apparent lack of interest in attending group sessions after initial contact on release suggests, however, that outside groups have a different function from inside groups.

The ex-prisoner who is "making a go of it" wants the security of knowing that there is a group to whom he can turn if he is in difficulty. Thus, the dissolution of the group can be seen as a positive sign of the successful rehabilitation of members. The successful ex-prisoner has to merge himself, his interests, and value systems with those of the rest of the community. Any attempt to prolong dependence upon outside groups would prevent rehabilitation. If outside groups are flexibly organized, with the therapist content to play a steady "initial" role in the group and then a reliable occasional contact as an individual, the techniques of therapy can be developed and extended to the difficult area of criminal reclamation.

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A STUDY OF RESISTANCES IN A MEMBER OF A THERAPY GROUP

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The signal importance which Freud (1920) attributed to the concept of resistance is demonstrated in the *Introductory Lectures on Psychoanalysis* in which he states:

The labor of overcoming the resistance is the essential achievement of the analytic treatment; the patient has to accomplish it and the physician makes it possible for him to do this by suggestions which are in the nature of education. It has been truly said therefore that psychoanalytic treatment is a kind of re-education.

Fenichel (1945) has defined resistance as "everything that prevents the patient from producing material derived from the unconscious." Menninger (1958) offers a broader definition: "the trend of forces within the patient which oppose the process of ameliorative change." In a study of resistance in group therapy, Spotnitz and Gabriel (1950) directed group members to give a spontaneous and emotionally significant account of their life histories, thoughts, and ideas and to help each other to do the same; the voluntary and involuntary methods by which the members avoided presenting this material were considered the resistances.

This paper will describe the group adjustment and examine the resistances of one group member as they emerged in the weekly sessions of a group of mothers in a child guidance clinic treated in accordance with principles of analytic group psychotherapy delineated by Slavson (1950).

THE PATIENT

The Shaw family was referred to the child guidance clinic by a family agency to which the mother had applied because of her concern about her son Arthur, then aged ten. She found it difficult to cope with his temper outbursts and demandingness and was anxious about his provocative and aggressive school and social adjustments. He was diagnosed as a behavior disorder and demonstrated overdetermined aggression with a tendency to veer between suppression of all spontaneity and explosive reactions. Arthur and Mr. Shaw were seen individually in the family agency while

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Mrs. Shaw participated in group counselling, supplemented by individual interviews for a period of one year, after which time they were referred to the child guidance clinic.

Mrs. Shaw had three older sisters and a fraternal twin. The referring material described her deep feeling that her twin brother was much preferred, that she was only a fourth girl in a family dominated by her mother with a weak father on the periphery. Strong ambivalence toward males, a deep dependency problem, depressiveness, and defensive use of hostile withdrawal were seen as major facets of her personality at the time of referral.

Although Mrs. Shaw had married partly to escape the parental home, her relationship with Mr. Shaw was quite meaningful and the early period of the marriage was apparently the happiest time in the lives of each. Mr. Shaw was described as a considerably disturbed person with varied somatic complaints and difficulty in expressing anger. It was on Mrs. Shaw's insistence that they had had children. She longed desperately for a girl and was intensely disappointed with Arthur's birth. There were two younger children, a girl and boy. Problems emerged with Arthur when his demands changed from those of an infant to those of a more active and aggressive child as he approached the age of three.

Despite initial anxiety, Mrs. Shaw had found the group counselling experience a highly stimulating one and it seemed to have affected her self-esteem positively. The referral report noted that although she was quite negative and hostile to the male group leader, she expressed strong feelings of hurt and abandonment when he left the agency.

Arthur, aged eleven at the time of the family's referral to the child guidance setting, entered activity group therapy. In several exploratory interviews held with Mrs. Shaw by a caseworker, she expressly requested a further experience in a group.

GROUP ADJUSTMENT

First Year

Mrs. Shaw entered the group in December and attended all thirty sessions through the treatment year. In this first year she assumed two overlapping roles, beginning with that of the adequate, advising, perceptive, and interpreting co-therapist and then presenting herself as the silent sufferer. In pursuit of the former role she astutely pinpointed the underlying motivations and conflicts of fellow members. When one sought seductively to have the therapist interpret a sexual dream, Mrs. Shaw observed, "She wants you to put the key in the lock for her." When another reported dropping a dish when expecting her period, Mrs. Shaw remarked "You probably

resent being a woman," adding that she herself was quite accepting of her own menstruation. One of her frequent responses to problems posed by others was, "I *used* to do exactly what you're doing now."

In her fifth session she participated in a discussion of familial relations, noting, "We're a funny family. We rarely see each other but we're very close." She continued that she and her mother had had a poor relationship in the past but that "now we get along and that's enough for me." She added emphatically that she had "solved" this problem and no longer was concerned about it. Here she seemed to be advising therapist and group to stay clear of an affect-laden area.

The initial resistance met its first direct challenge in Mrs. Shaw's seventh session when another member pointedly commented on her pattern of relating only to the problems of others. This confrontation was disarmingly handled by Mrs. Shaw who calmly replied, "That's my major problem, revealing myself and discussing my own problems." The confronting member, apparently mollified, did not pursue this further. However, later in the session Mrs. Shaw opened the door briefly as she told that she had received very little from her own mother and in turn gave little to her own children.

Mrs. Shaw revealed a different aspect of herself in the following session when she arrived looking obviously troubled and unhappy. When the therapist suggested that it would be helpful for her to voice her feelings, she explained that she was sad because she was unhappy at home, though contented at work (part-time secretary in a group work agency). Up to this point, direct contact between Mrs. Shaw and the therapist had been minimal.

In her twelfth session she arrived brimming with unvoiced anger and resisted all inquiries from the group as to what the matter was. The therapist then remarked that if the members and himself really wanted to be helpful to Mrs. Shaw, they would read her mind and know exactly what was hurting her and what she needed without having to ask her. This released Mrs. Shaw. With a murderous glance at the therapist, she explained that she had been "stewing with rage" at him since her very first session due to the use of last names in the group which she considered an affront. She expressed great anxiety about the possibility of leakage, through a highly orthodox group member who lived in her general neighborhood, of her own irreligious attitudes. She feared that these might get back to her in-laws, whom she described as religious leaders in the community. With impressive intensity she proclaimed her responsibility to protect her in-laws' reputation and "not drag them down." While this outburst appeared to represent a displaced expression of her own fears of being dragged down

and humiliated in the group (community) through exposure of her impulses, the therapist did not comment on this. He did, however, express approval to her for doing a good job of expressing her feelings. Her fellow members noted their own comfort with the use of surnames and wondered why it had taken her so long to express her resentment.

In the succeeding session Mrs. Shaw was again the critic, adviser, and appraiser. When another member noted this, Mrs. Shaw asked with considerable interest, "So what am I doing to the group today?" She then answered her own query with, "It sounds like I'm trying very hard to be superior." When reference was made to a TV production of *Medea*, she noted that she was like Medea in that she took out on the children her anger toward her husband.

In her fifteenth session Mrs. Shaw sat in mute suffering. In response to the group's interest, she implied a specific concern which she was unable to voice. The therapist then expressed interest in the feelings which were preventing her from talking about her troubles. With this she voiced a fear that she might break down and cry. When assured that she had a right to cry and that the therapist would not permit her to lose control over any of her feelings, she expressed relief and then shared a specific concern with the group, the fact that her husband was faced with the possibility of an abdominal operation. She expressed powerful feelings of repugnance at the idea of a scar and was fearful that she might reject her husband if he were scarred.

For the next five sessions, she became again the penetrating observer of the foibles of the other group members. When faced with this by them, she expressed a wish to talk about her life and to obtain help but an inability to do so. At the group's suggestion, and with Mrs. Shaw's agreement, an individual interview was arranged for the following week. Two days prior to the appointment, she called to ask if the therapist would talk to her husband who was suffering from severe insomnia, who seemed quite upset, and who had concurred with her suggestion that she call. The therapist held a phone conversation with Mr. Shaw who indicated concern about the recent failure of his retail grocery and about his hostile feelings toward his family. He said that he had it in for everybody who was better off than he. Possible treatment contacts were discussed with him.

In her individual interviews Mrs. Shaw said her husband had reacted very positively to the phone contact with the therapist. She went on to present him as considerably disturbed (more so than herself). Concerning her own group adjustment, she spoke of wishing to be capable of talking about her own inner unhappiness. She cited her anxiety about Arthur's approaching Bar Mitzvah, remarking that it would help her to discuss this

in the group but that somehow she could not. She spoke of using the group sessions productively and of finding herself freer to talk than in her previous counselling group. She reported that after the last group meeting she had gone home and tried to help Arthur do what she could not, namely, "to talk and to communicate." She implied that she eventually would talk provided no pressure was exerted on her. She also revealed a fear that she might be expelled from the group for not talking.

Just prior to the end of Mrs. Shaw's first treatment year, the therapist saw Mr. Shaw, who reported certain improvements in his wife. He noted that at times she could be happy, in contrast to her pervasive sadness in the past; that she no longer dressed herself drably and neglected her appearance; and that she was now making friends whereas previously she had been isolated. He also felt she was nicer to the children.

In the final session of the season, Mrs. Shaw reported successful handling of her daughter's un verbalized jealousy of Arthur's Bar Mitzvah. Mrs. Wilson accused Mrs. Shaw of being a therapist with her child and also charged her with reporting only success in the group. Mrs. Shaw replied, "Well, I have failures, too. My younger son wets the bed." The therapist asked why she was telling this now, and Mrs. Shaw grinned and said tartly, "Well, maybe it will make Mrs. Wilson happy."

Thus, during the first year there was a gradual revelation of personality counterbalanced by powerful forces at work to prevent the unfolding of a life story. The emerging resistances seemed to take the form of apparently opposed polarities: (1) the wish to appear adequate, superior, undamaged, and unscarred, but at the same time (2) self-presentation as the sickest and perhaps the youngest (baby) in the group by virtue of mute suffering and un verbalized need.

Second Year

Mrs. Shaw attended forty of forty-one sessions in her second year. She began with a resumption of her co-therapist role, and the therapist supported her resistance by occasionally asking her opinion of the nature and meaning of emotional transactions in the group which did not directly involve her. When, at one point, the therapist planfully praised her for her helpfulness to others, she smiled and remarked quizzically, "Yes, isn't it strange. Why can't I help myself?"

In the succeeding session the group members were asked what each considered their most pressing problem. Mrs. Shaw, who had until then been secretive about her marriage, unhesitatingly replied, "The marital situation." In response to group inquiry, she disclosed that her husband had a need to take over her role in the home by doing the housework and

cooking. She explained that for a long time she had been emotionally unable to cook nice meals for her family or to keep the house neatly; now that she had begun to want to do these things, he could not seem to accept it and, consequently, she lashed out at him in anger. In the same session she recalled never seeing any love in her own family and told of harboring such "tremendous" hostility toward her mother that "I can't even look at her."

A crucial dynamic in the process by which Mrs. Shaw began to feel and express her powerful feelings toward her mother was the intragroup transference she developed toward Mrs. Wilson, a tall, spare, rather critical and ungiving person. An excerpt follows from the specific session in which the transference made itself manifestly visible.

Mrs. Milton had begun with a lengthy outpouring of feeling around her child having been called "moron" by a teacher. After awhile, Mrs. Wilson expressed annoyance with the "petty nature" of the discussion. Mrs. Shaw exclaimed angrily, "You always consider anyone else's problem as petty!" Mrs. Wilson, with heavy sarcasm, retorted, "Maybe you're too advanced for this group." Then, activated by Mrs. Shaw's statement, Mrs. Wilson went on thoughtfully to examine her own capacity to share with the group. Mrs. Shaw withdrew into a hurt and angered silence. When the therapist remarked upon the feelings she seemed to be containing, Mrs. Shaw acknowledged them. She proceeded to convey feelings of being under constant attack from Mrs. Wilson. With sadness and longing, she recalled that when she first entered the group, Mrs. Wilson had been warm and accepting and had implied that she would never attack her. As she continued to express hurt feelings at Mrs. Wilson's changed attitudes toward her, the therapist said that it sounded as if she felt betrayed by Mrs. Wilson. Mrs. Shaw eagerly confirmed this. A pause ensued and Mrs. Shaw then said quietly, "I know why I'm so upset. Mrs. Wilson is my mother here."

Several sessions later Mrs. Shaw sat in saddened isolation. Upon questioning, she revealed unhappiness, insomnia, and inability to cook for the family after having been able to do so for awhile. She felt that treatment was approaching something which was frightening her but could not explain this further.

When the members evaluated each other, Mrs. Shaw said of Mrs. Wilson, "My impression of her, it stinks!" Shortly after this she became obviously upset and turned away from the group. When pressed by the others to talk rather than to "stew in your own juices," she tearfully said she was upset, that she did not know why, and that she wished to be left alone.

In one mid-year session, Mrs. Wilson deplored the "cold intensity" of Mrs. Shaw's generally unexpressed resentment toward her. This led to other members disclosing the anxiety-producing effects upon them of Mrs. Shaw's

unexpressed feelings. Mrs. Shaw was quite interested in this and asked, "You mean it's a form of hostility?" To this, Mrs. Knight offered an emphatic "You bet!" A week later Mrs. Shaw was present with only one other member, Mrs. Knight, the "baby" of the group. In the absence of the more adequate members, she seemed freer and was able to discuss her withdrawal from her husband and children. She said that she sensed a tie-up between her withdrawal and anger. The therapist asked what might happen if she did not protect her family from her anger by withdrawing; might she kill, maim, or dismember? With eager relief Mrs. Shaw replied, "Dismember is exactly the right word!" She reported frequently thinking of scissors as a weapon and of once having to hide all of the knives and scissors in the house. She presented an odd story of continually pinching her son Arthur and then being resentful that he did not lose weight "as a defense" against her pinches. She added "It's true, I always hated his guts."

In bitter tones Mrs. Shaw recalled that her brother was welcomed in the family, whereas she was unwanted. She recognized the displacement as she noted that recently she had been calling Arthur by her brother's name. She also acknowledged instigating conflict with Arthur by her constant criticism and domination. A burst of hatred toward her mother climaxed this session for Mrs. Shaw. This release of aggression continued into the ensuing meeting when she lashed out at Mrs. Wilson for a remark the latter had made a year earlier.

In the middle of her second year, when the members evaluated their treatment, Mrs. Shaw described experiencing strong discomfort and a wish to avoid coming. She said, "My life is torture right now but I see this (group treatment) as my only hope." When asked about the possibility of individual treatment, she explained that she had thought about it, felt she needed it, and yet was just too afraid of it at this point. The entire group then agreed that an appropriate goal of Mrs. Shaw's group treatment would be that of helping her become strong enough to accept individual therapy at some future time.

From this point on there was a sharp upsurge in the spontaneous expression by Mrs. Shaw of feeling toward fellow members and the therapist. She voiced her appreciation of and gratitude toward him and also indicated her "subconscious" dislike for social workers. On the one hand, she seductively sought to have the therapist get her to "open up" and reveal something she was withholding; on the other, she emphasized her contempt for social workers she had met who were cheap, stingy, eccentric, and disorganized. Her attitudes toward Mrs. Wilson took on an obviously rivalrous quality, and she accused her of inordinate interest in the therapist.

A significant childhood memory which rendered her silent suffering

pattern more understandable was that of punishing her mother by not telling her when she was sick.

When the therapist investigated their underlying needs in the treatment experience, Mrs. Shaw offered spontaneously, "We come here to express hostility." When other members presented oedipal material she reacted with discomfort and accelerated breathing. In this same period she reported having entertained fifteen guests and of having gratefully accepted her mother's help with this event.

Intermittently, in an intensely demanding, pressuring, and critical manner, she would interrogate the therapist as to whether Arthur was making progress in treatment. When, in the face of this, the therapist felt wishes to expel her from the group, she then complained about abandonment by the therapists in the family agency. On one occasion when she was particularly belligerent, the therapist asked why she was trying so hard to be disagreeable. Mrs. Shaw smiled and said she guessed she was trying to get him to throw her out. The therapist suggested: "If I did that you could get out of treatment without feeling guilty; you could hate me and not have to grow up any further." Mrs. Shaw grinned broadly as she said, "You've got the general idea."

In the spring of her second year, she reported an onrush of improvement in various areas: her own and her husband's relationship to Arthur, her relationship to her brother. However, when the therapist investigated the basis for these reports, Mrs. Shaw grinningly conceded that she was trying to get out of the treatment which was causing her continued discomfort. She then expressed appreciation that she was understood and voiced the wish that she be encouraged to remain in the group and make progress.

When the members discussed the attitudes toward femininity and masculinity which they had developed in relation to their parents, Mrs. Shaw plaintively observed, "I must be neither man nor woman; I hated my mother and my father was a nothing." She then, however, noted with distaste that she had taken on all the traits she disliked in her mother.

Speaking of her depressiveness, she commented sadly, "Everyone I've ever known in my life has disappointed me, including myself." She also felt an inability to "come alive." "I guess my problems started the day I was born; in a way, I was stillborn." She described murder and aggression as the dominant theme of her current family, noting that everybody connected with Arthur talked of wanting to kill him. She remarked that she had only become aggressive at the time of his birth; prior to that "I had no idea I was angry. I was just moody and depressed. In a way I guess all of the poison in me has been coming out at Arthur."

Her feelings toward other familial figures also found expression in an

outpouring of jealous anger toward two well-to-do sisters and in unrelenting vindictiveness toward a third sister who had given Arthur only five dollars on his Bar Mitzvah. As Mrs. Shaw reflected on her outburst, she stated, "I guess I'm a pretty angry, jealous, and unforgiving person." She also dropped her protectiveness of her husband and openly described him as a severely limited individual upon whom she had never been able to depend.

As her second year of the group treatment drew to a close, Mrs. Shaw noted her ability to function more adequately in a variety of life situations, specifically emphasizing her diminished need to identify automatically with Arthur in any of his rebellious encounters with school authorities. She summed up, "In some ways I feel much less hostile. I guess I've expressed a lot of it here."

Third Year

The third year witnessed an increasing exposure and release of Mrs. Shaw's feelings of deprivation and anger at her downgraded position in her family of origin, her psychosexual confusion, and her interest in perverse behavior. Also brought into the open was her need to stimulate others to enact her own impulses. This general advance toward the conversion of feeling into language and the attainment of control over feeling was interrupted by periods of sullen withdrawal and ungivingness which commanded group attention, protected the group from her hostility, and repetitively enacted a striking back at the ungiving (group) mother.² Concurrently, the transference relation with Mrs. Wilson continued to enable Mrs. Shaw to ventilate and drain off the rage she harbored against her mother.

The hidden side of her feelings toward Mrs. Wilson emerged in one session: in the midst of making a sarcastic rejoinder to one of Mrs. Wilson's criticisms, Mrs. Shaw stopped and revealed that it had just crossed her mind that, "Wilson will come down on me on all fours when she hears this." She added, "I know this is a very sexual thought." In another session a member reported an encounter with an apparent Lesbian. Mrs. Shaw, silent until this point in the session, reacted with growing excitement. She referred animatedly to orgies she had heard of, to foreign movies dealing with sexual misconduct, to a woman friend of her own who liked to hold her hand. She also told of having gone with friends to a nightclub where males dressed as women danced together, and noted that she was the one who enjoyed it most. She wondered, "Do I prefer men that way?" In subsequent sessions, as she described her relationships with women friends, the group commented on the masculine role she seemed to assume.

² Slavson's notable contribution that the group unconsciously represents a mother to its members is a valuable conceptual tool in the understanding of this case.

In the face of increased exposure and self-confrontation, Mrs. Shaw again became uncomfortable and desired to leave. She was prevented from doing so, she explained, by a statement the therapist had once made that she might some day want to leave the group in anger. (This illustrates the value of a prophylactic prediction.)

A demand by one of her sisters that she contribute to their mother's support triggered intense expression in the group of Mrs. Shaw's feeling complex toward her family. She argued vehemently: "Let my sisters give to her. They got more from her than I ever did." She bitterly indicted her mother and sisters for having inadequately prepared her for life. "They never taught me how to dress, how to make up, how to talk. I grew up not knowing anything." Mrs. Shaw wept as she said of her mother, "In no way did she prepare me for a life, for being a woman, a wife, a mother, for nothing." She described herself as the black sheep of her family. Other members reported experiencing similar feelings of worthlessness, exclusion, and rejection in their families. As the session closed, the therapist commented warmly that this was the nicest group of black sheep he had ever had. Mrs. Shaw smiled and stated confidently, "Here we're not black sheep; here we're wanted."

In succeeding sessions she recognized that her repeated encouragement of Mrs. Knight to "go out and have a good time" stemmed from her own interest in having an affair. In a session which centered around the members' stimulation of their children to improper behavior, Mrs. Shaw reported giving a sexy book to a friend. When asked about this, she replied, "You know by now that I go around stimulating others." When she described rather wild parties which her group of friends held, Mrs. Wilson remarked seriously, "I think you're above this and that you and your husband should find other friends."

As the year closed, Mrs. Shaw reported a considerable improvement in her relationship with Arthur. She indicated that for the first time she was enjoying him as a son, was beginning to understand him, and "more importantly, I want to understand him." She noted that when they first came to the agency, "We were both animals; now we're human and can talk to each other." She described their significantly enhanced ability to put anger into words (these gains were corroborated by Arthur's therapist). When another member commented that Arthur's therapist had done a good job, Mrs. Shaw stated proudly, "I deserve the credit; I brought him here and I worked at my treatment." She continued that she is now able to listen to others and has heard what other mothers do for their children. "I realize that all I've done is to push my kids away. What kind of life is that, to push them away?"

RESISTANCES AND THEIR HANDLING

Study of Mrs. Shaw's three-year group adjustment reveals a variety of voluntary and involuntary measures utilized to avoid or oppose the stated aims and tasks of the group. Initially, rather than risk exposure as damaged and scarred by telling her own life story, she used her perceptiveness to interpret the problems and to advise on the behavior of her fellow members. This conscious resistance was overcome by the joint efforts of the group and therapist. The other members showed continuing interest in Mrs. Shaw's own feelings and refused to be satisfied with her comments on their feelings. The therapist's support of this resistance enabled her to retain it as long as her psychic exigency required; his use of her as a "consultant" conveyed that he saw her as adequate, thus lessening her need to prove it.

The second resistance, which consisted of looking and acting unhappily rather than talking about the feelings which were causing her suffering, extended over a long period and overlapped other resistances. It did not succumb dramatically at any given point to an adroit maneuver or inventive technique but rather underwent a gradual erosion as Mrs. Shaw's investment in treatment increased. This resistance appeared to meet a number of significant emotional needs for her, among them the wish for infantile dependency and the accompanying privilege of having her needs met without having to verbalize them. It also served to defend the group and the therapist against her rage while at the same time exercising a hostile and controlling function. It operated simultaneously as an effective attention-getting device. The gradual diminution of this pattern occurred under the cumulative pressure of a variety of countermeasures: (1) repeated and consistent efforts by the therapist to educate Mrs. Shaw to the advantage of expressing her feelings in language; (2) education of Mrs. Shaw by the group of the hostile and controlling effect of her nonverbal periods; (3) assurance by the therapist against loss of control; and (4) the repeated angry exchanges with Mrs. Wilson and the acceptance of her anger by the therapist, which demonstrated again and again that verbalized anger did not kill.

At times, in the face of feelings which threatened to become too painful to assimilate, Mrs. Shaw demonstrated resistances designed to achieve flight or expulsion from the group, e.g., she presented wholesale improvement or acted provocatively toward the therapist. These maneuvers were addressed by exploration, analysis, and by alerting the patient in advance that, under the pressure of certain feelings, she might seek to interrupt treatment.

Another resistance emerged as the expression of anger simply for the

gratification of discharge without any accompanying attempt to examine the feeling and life situation supplying the anger. This was handled primarily by Mrs. Shaw's own self-awareness and wishes toward health.

Finally, there were the transference resistances expressive of the patient's resentment and frustration at not receiving certain responses and gratifications from fellow members and the therapist as representatives of significant earlier figures. For example, she sought from Mrs. Wilson the unconditional acceptance she never received from her mother; failing to attain it, she hated her. Or, she provoked Mrs. Wilson to attack and then looked to the therapist for the protection her father did not afford her against her mother's assaults.

A salient dynamic which emerged as a resistance was the need, based on a powerfully influential childhood prototype, to punish the mother (therapist-mother and group-mother) by suffering. Related to this was the need repetitively to experience being the deprived child. In the shadings and nuances of the transference to the therapist, he at times represented the hated brother with whom she competed; while in matters of treatment fee, summer camp for Arthur, and assignment to treatment of other family members, Mrs. Shaw appeared to view him as a good father when these matters were handled in accordance with her wishes, as the ungiving mother when she was frustrated.

COUNTER-RESISTANCES

The feelings activated by patients in the therapist have been referred to as "counter-resistances" or in totality as the "induced neurosis" (Spotnitz, 1952). Our patient, in her mutely suffering periods, generated in the therapist anxiety, discomfort, and a strong wish immediately to alleviate her private suffering by inducing her to talk, at times irregardless of the contemporary needs of others in the group. When his ameliorative efforts were unsuccessful, the therapist felt deprived of therapeutic satisfaction, inadequate, and consequently resentful. Another aspect of her silence was its perception by the therapist as a form of sullen defiance which he frequently felt impelled to subdue and overcome by persuading her to verbalize. He thus at times found himself in the role of the mother trying to force a negativistic child to eat. Conversely, when she expressed her feelings in language, the therapist felt approval for her. At times the therapist experienced strong wishes to expel her, especially on one occasion when she reported having uncontrollably beaten her younger son.

In exploring those feelings which were induced in him and, in a sense launched at his ego by the patient, the therapist was enabled to perceive *emotionally* something of what her ego had been subjected to. The resist-

ances thus may be viewed as an indirect form of communication of life history. The resistances are also instruments used by the individual (group member and therapist) in helping himself to adjust to the emotional stress created by group membership, group functioning, and the infinite variety of feelings and impulses stirred up within the dynamic matrix of group psychotherapy. Understanding the resistances, their origin and meaning, and the feelings behind them greatly enhances the therapist's total understanding of the individual. In his recognition of the psychological need for and value of the resistances and in learning to lead his group members to a gradual understanding of their resistances, the therapist conveys his respect for their contemporary emotional needs, energizes members' potentials for health, and enhances his own emotional and professional growth.

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EVALUATION OF A THREE-YEAR GROUP THERAPY PROGRAM FOR MULTIPLE SCLEROSIS PATIENTS

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Multiple sclerosis is a debilitating disease of unknown etiology. Its course is uncertain; it can be acute or chronic, progressive or remittent. The disease process involves degeneration of the protective white insulation sheath called myelin which surrounds the nerves in the central nervous system. This and the inevitable scarring causes short-circuiting of the nerve impulses from the brain. The resulting symptoms vary depending upon the areas of the nervous system which are affected. Sensation, vision, gait, speech, sphincter control, and fatigue may be involved individually or in combinations. Prescribed treatment is symptomatic and/or supportive (Schumacher, 1950; McAlpine et al., 1955). Symptomatic treatment is not always possible or successful. Supportive treatment is seldom available. The patient is frequently left alone to deal with the disease and its impact on his life. The problem, therefore, is a complicated one.

Little is known about the adaptation of patients to this disease. Investigators have pursued the issues of brain damage, euphoria, depression, mental symptoms, and emotional conflicts. These approaches have been specific and designed to study the patient at only one point in time or for only a brief period. Since the disease process can fluctuate, such specificity and short-term study impose limits on the understanding of the patient with the disease.

Group programs for multiple sclerosis patients which lasted from six months to two and a half years have been reported. Day et al. (1953) found that these patients handled painful issues and anxiety by denial, scapegoating, and projection. Barnes, et al. (1954) were primarily concerned with using group therapy as a means of helping patients deal with dependency problems which were bothersome to the treatment staff. Long (1954) commented upon defensive handling of feeling and dependency as a problem, remarking that anxiety about the disease ran counter to the group process. Bolding (1960) agreed that the patients used denial to handle anxiety and feeling.

This paper also deals with a group therapy program for multiple scler-

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rosis patients. Since the complexities and interrelationships of such a program are many, they cannot all be dealt with in one paper. We have elected to focus here on (1) the use these individuals made of the group and (2) some of the problems involved in the leadership of such a group.

METHOD

Eight patients were chosen at random from the population of the Multiple Sclerosis Outpatient Clinic³ of Falk Clinic.⁴ The diagnosis of multiple sclerosis, not the presence of psychiatric problems, was the primary criterion. The patients were told that the group program was designed to explore and help them and others with the problems that develop as a result of the disease. Each person was interviewed at least once before being placed in the group. The group met weekly for an hour. A psychiatrist and a psychiatric social worker were co-leaders. A second social worker observed. All sessions were tape-recorded.

THE MEMBERS

The group consisted of three men and five women. One of the women was single; another was divorced; both lived with their families. The rest lived with their spouses and children. The age range was from 26 to 43, with the average age being 35. One woman was Negro.

Duration of illness ranged from one to fourteen years, with the average duration of illness five years. Six of the people could walk with minimal difficulty. Two women wore braces and used crutches. One man and two women had visual difficulties.

FINDINGS

The members could be described as having been adequate, active people prior to the onset of the disease. All were still involved in business or household duties. Economically, they were middle or lower middle-class. The early histories of all but one revealed poverty and deprivation. They came from hard-working but complex and angry families who seemed to have few channels for expressing feeling.

The common bond of multiple sclerosis was predetermined by the selection of the group. In the first meeting each person gave his name, then commented on who he "used to be" (a salesman, a bank clerk, etc.) or what he "used to do." Everyone seemed afraid to admit he had the disease. Each one had withheld or was withholding the knowledge of his illness from his family, friends, and employers. They revealed or were planning

³ Financed by the Western Pennsylvania Multiple Sclerosis Society, Inc.

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to reveal the fact that they had multiple sclerosis only when their symptoms became so obvious to others that some explanation was necessary.

The first meetings turned out to be equivalent to a confrontation of the members with the realities of their disease. Each member surveyed the others. Those with obvious impairment looked with anger at those without it. The latter looked with quiet horror at those with crutches and braces. The members wanted to listen rather than to talk; they were silent, anxious, and resistive. The leaders were made to work hard to justify the value of the group. In spite of the resistance evident, some members came from long distances, others took time off from work, and others had to make weekly arrangements to be brought in.

When the members did begin to talk they seemed to have an unspoken agreement not to show direct anger or annoyance to either each other or the leaders. They related to one another on the basis of their illness. There was no overt interest or curiosity about one another as people. Degrees of disabilities were discussed in terms of what individuals could still do. First symptoms, time of diagnosis, and length of illness were talked over with apparent calm. Their questions indicated, however, that each person was concerned about how fast and how seriously the others had been affected by multiple sclerosis. They wished to know more about the disease; yet their fear of knowing was obvious.

One man became the general spokesman for the group, asking innumerable questions. Our answers furthered the members' understanding of the disease and the symptoms, but they also continuously pointed to the fact that medicine had no cure. The spokesman brought in and reported on articles from newspapers and popular magazines. He engaged the group in discussions of remedies they had tried and retried. This reworking of the facts and fantasies was advantageous to a degree. As the members became more informed about the disease they began to feel less apprehensive and shameful. The frustrating wish they had had for a magical cure was transformed to some degree into a hope for effective research.

The group was content to keep the discussion at this level. They presented a solid front to the leaders in dealing with questions, answers, and comments. There was little interaction between them. They did not discuss family or interpersonal relationships. Yet, tensions in the individuals and in the group were apparent. Efforts on the part of the leaders to interpret this or initiate discussion about it were met with such statements as, "Everything is fine." This stalemate came to an end when two relatives of group members contacted the Multiple Sclerosis Society's social worker. Each relative expressed deep concern over their respective situations in which both members were expressing jealousy, anger, and rage in their

homes to such a degree that the families could not deal with it. A third report from a school psychologist indicated that another member was extremely sweet to her child until she thought she was out of sight and hearing of the teachers; she then treated him brutally.

When the family concerns were made known to the group, members reacted with anxiety and shame. Two dropped out. The remaining six were able to discuss some feelings of anger and frustration about their disease and how it complicated their home lives. They revealed that these outbursts had been episodic over a period of time. Their major concerns seemed related to their feelings of physical and sexual inadequacy. The problem of feeling adequate was an old and major one for all members. Prior to the onset of the disease they had been able to be much more physically active. This afforded them reassurance, outlets, and feelings of accomplishment. As a result, their personal and family lives were less complicated. It was around the problem of adequacy that most of the group's interaction centered. From time to time every member of the group succeeded in provoking the rest of the group and the leaders by stubbornly insisting that he was or had been inadequate at work, school, and in family life. No matter how many times each member recognized the others' unrealistic self-appraisals, he could not see that he also was being unrealistic. The group reacted with anger and frustration at such times.

The group became outwardly supportive of individual members who suffered exacerbations of physical symptoms. Their real fears and anxieties were not talked about until the affected patient was absent. Then they expressed feelings of pity for that person and relief that it was not they who had the trouble. After this, they always retreated to asking questions about "cures" and "research." They showed little curiosity, interest, or concern about members who dropped out. It seemed as though such inaction on their part was an attempt to keep things as they were or to deny change.

The sessions revealed that anger and frustration seemed to have been a major factor in the early lives of these people. One parent, usually the father, was described as being unreasonable and cruel in his methods of controlling or disciplining the individual. For example, the father of one woman used to punish her by lifting her by her neck. The father of another member, described as being extremely remote and exacting, would beat his son if the work was not done as he thought it should be. It was also characteristic that these members from early childhood showed painful striving to please the less punitive parent. The extent to which they would do so was remarkable. As a boy, one man earned all the money he could to please his mother. As an adult he had three jobs. From his earnings he bought the best of everything in hopes that his indifferent mother would

find him acceptable. Another member had, at a very early age, assumed most of the household duties and continued to do so after her marriage. The situation of overwork was constantly frustrating: she could never give up; her mother could never be pleased.

At the risk of oversimplifying a complex situation, we would like to suggest that this material helps to explain why there was minimal interaction within the group. These people had to be pleasing. They feared brutality, while their rage boiled within.

A group cannot be evaluated accurately without some consideration of the leaders' experience as well as of the problems such a group presents. The previous experience of both leaders had been with groups in which the problems were primarily functional disorders. In retrospect, it appears that the expectations of the leaders were that this group would be no more and no less complex than other groups. This was not the case. This group presented the leaders with unique problems. First, these people did not come into the group ready to deal with emotional problems. It was the fact of having multiple sclerosis that initially motivated the members to attend the group. A second problem was that the leaders as well as the members were uncertain about this disease for which no course or prognosis could be established. Also, there is real question about whether or not people can be helped to work through feelings about possible debilitation and further handicaps. Discussion of this loaded subject can frequently be or almost be prevented by collusion between leaders and group members.

DISCUSSION

In reviewing the total group program it would appear that the members benefited. The fact that they were chosen for the group meant that they were special and people cared about what was happening to them. They felt less isolated and unique. All of them seemed less ashamed about their disease. The factual data about the disease eliminated many of their disturbing thoughts or fantasies. Follow-up with families and comments from family members indicated that four improved their family relationships, two improved their work relationships, while the remaining two seemed to gain no more than reassurance.

We would agree with Long (1954) that anxiety about the disease runs counter to the group process and makes interpersonal action within the group difficult. However, we would like to take this one or two steps further. There may be other factors in addition to the disease itself which prevents interpersonal action. We would suggest that one was the quality of the early parental relationship. Closely allied with this is the quantity of

anger these people feel they have, and fear. It is the writer's impression that such a group as this could not be expected to function or interact in a traditional fashion. The problems these people are facing are different in emphasis and degree than those of people who are attempting to resolve neurotic conflicts only.

We would suggest from our experience that family contact should be an integral part of any program for patients with multiple sclerosis. The group members were struggling with the problem of having to become less adequate in relation to their families. The families were struggling to deal with this problem and needed help too. (It was at the point of family contact that the members were able to bring out more feeling and problems.)

We would also agree with Day et al. (1953), Long (1954), and Bolding (1960) that these people handle anxiety and feeling with denial and projection. Our material indicates, however, that they do not deny feeling and anxiety as completely as these authors suggest. These people appeared placid and conforming in the group, but at times they were overtly angry and upsetting with their families. When this dichotomy was recognized, feelings and anxieties could be talked about more directly in the group. A review of the tapes and transcriptions of the tapes were also helpful in defining ways these people handled feelings. When listening to them, it became evident that there had always been comments about anger, frustration, anxiety, and other feelings which had not been heard. There were many such comments as: "I go to my room and cry alone"; "When I am angry I try to get away"; "I became so frustrated I threw a jar across the room."

Statements about feelings had gone unnoticed by the leaders because of the manner in which the members expressed themselves. Critical situations were discussed with apparent indifference. To hear what was said on the tape and then to read a transcription of the same passage was startling. The members made many statements in such a way as to say: "I found the situation horrible and terrifying but it did not bother me." It seemed they were expressing and denying feeling at the same time.

This problem of expressing feeling is a complicated one. The dilemma of these people is neatly spelled out by the contrast between their functioning in the group and functioning at home.

Although it is generally thought that there is no multiple sclerosis personality, the similarities among these people were impressive. This needs further investigation also. It is only possible at this point to say that these people were all facing the same threats: (1) uncertainty; (2) possible dependency; and (3) real inadequacies in addition to fantasied inadequacies.

In summary, from this limited study we can say that a group therapy

program has value for patients with multiple sclerosis and is an effective research aid. Such programs can expect to meet complications resulting from the factor of a debilitating disease. The defensive patterns and communications of these individuals are complex and need a great deal of additional study.

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THE FAMILY INTERVIEW AS AN INTEGRATIVE DEVICE IN GROUP THERAPY WITH FAMILIES

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This paper is concerned with the use of family interviewing as an adjunctive treatment process to group therapy. The co-authors, staff members of the Jewish Family Service of New York, shared therapeutic responsibility for several families as therapists of a married couples group and of an adolescent girls group respectively. In their work with families whose adolescent children present serious behavior and emotional difficulties, the writers have been influenced by the concepts of Ackerman (1958), Sherman (1961), Mitchell (1961), and other workers in the field. Generally speaking, these concepts, relating to family diagnosis and therapy, are based on the premise that an individual's growth is either stimulated or thwarted by the transactions occurring within the family as a whole and that, therefore, treatment intervention aimed at a modification of intra-familial processes would tend to ensure more reliable change in the individual than would exclusive concentration on intrapsychic phenomena.

The writers, strongly convinced as to the efficacy of group therapy, gradually developed a treatment technique in which group therapy and family therapy were meaningfully combined. Parents and children have been treated in separate therapy groups, but have been brought together from time to time in family interviews. This type of structure seemed to approximate most closely the writers' concept of the life process of the family and the different needs of its individual members at various points in their lives.

More often than not, family disturbance essentially is reflected in an inability of all members of the family to relate to each other; each person perceives the other as an insufficient provider, which often gives rise to very distorted mutual images. Basic in this is the inability of the marital pair, the parents, to use themselves in such a way as to promote growth of the entire family group. To the extent to which the other person is seen in terms of one's own need fulfillment, he cannot be perceived as a separate individual. Self-development of the individual, therefore, is felt as a tremendous threat to the survival of the family group. While it is essential for the child to be nurtured within the family, he needs at an early age to move out into

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the world and have an ever-widening range of experience beyond the confines of the nuclear family. Placing the child in a peer therapy group gives recognition to the reality of the child's need to learn to live with and relate to his peers as well as adults. In the therapy group the child is seen as a unique person in his own right and is held responsible for ever-increasing awareness of his feelings, actions and reactions, and their consequences.

In contrast to the children, the parents' future, in most instances, is with each other. However, because the marital relationship lacks vitality, the future is often a dreaded prospect; it is frequently for this reason that unhealthy attachments to the children are formed. In the married couples group the marital partners participate in a joint, meaningful, vitalizing experience. Much attention is given to marital interaction, but multiple cross-relationships spontaneously develop which permit the marital partners to reach beyond the restrictive bounds of the marriage and expand their actual life experience.

In the married couples group the pair-relationship of the parents is maintained intact, but the children, although often talked about in a highly distorted manner, are not part of this living experience. The children, in their group experience, also tend to present distorted pictures of the parents, either making them into monsters or ignoring their existence altogether. This phenomenon has led us to use periodic family interviews in which *the two separate treatment experiences are brought together into a new whole*. The participation of all family members in the family interviews is not always a necessary requirement. There are not infrequent occasions when two or three family members meet together, while those with less involvement in the specific area of conflict are not included.

The timing of the family interviews is variably determined by external or internal realities. Family interviews are always held at the beginning and conclusion of therapy because of the special significance of these periods, and they are also scheduled, when specific crisis situations are impeding further movement of the family. More complicated, because these externals do not exist, is the timing and use of family interviews which are needed because of the inner reality of the treatment situation.

THE FAMILY INTERVIEW AT THE ONSET OF TREATMENT

Many of the families who come to the Jewish Family Service seek help in relation to the disturbance of one of their children. Prior to any formulation of the treatment plan, we usually meet with all family members, involving them in a mutual consideration of what has gone wrong. As they begin to realize that more is involved than just the symptom that propelled

them into seeking help, the danger of the family sabotaging the treatment of the child is lessened. In the family interview the child witnesses some acknowledgment that he is not totally responsible for the difficulties, and he experiences some relief; this often serves to reduce his initial anger and makes him less resistive toward entering treatment. The therapist conveys to the family the feeling that he stands for greater health, a goal which seems to join with their own, at least at some level of awareness.

The following illustration may serve as an example: The S. family applied when their oldest son, Peter, an extremely bright boy in late adolescence, had been expelled from college after a period of nonfunctioning. Our initial family interviews included the parents, Peter, and his two younger sisters. The boy was diagnosed as extremely disturbed and in need of intensive individual psychotherapy, which he subsequently entered. While Peter's grave pathology and the upheaval caused by it were obvious in the initial family interviews, the therapist was impressed by the chaotic climate which prevailed in this outwardly well-functioning family. Most prominent were the strong rage which emanated from the two older siblings (Peter and his adolescent sister), their constant and violent attacks on each other, and the parents' helplessness and inability to cope with it. The therapist was aware that the intense outbursts of the allegedly nonproblematic, well-functioning middle child carried a plea to be heard and noticed, since the parents were overly preoccupied with Peter and showed marked preference for the more lovable and affectionate younger daughter. As some of these observations were shared with the family, the parents rather readily accepted treatment for themselves in a married couples group and therapy for the middle daughter in an adolescent girls group, which the girl herself was quite eager for.

While the marital problem was very apparent to the therapist, it was strongly held under cover by the parents, especially the father, who, for his own reasons, could make no demands on his emotionally impoverished and fragile wife. The therapist felt that the nature of the couple's denial of marital difficulties was such that an already existing married couples group would be more efficacious than either individual or joint treatment to help them gain greater self-awareness and a more realistic view of their relationship with each other. This example, incidentally, illustrates a frequent phenomenon which occurs when a family-oriented approach is used: the so-called well-adjusted child emerges (either at the beginning of treatment or later) as being significantly affected by or even contributing to the family disturbance; at the point this is recognized the decision is usually made to include the child in treatment.

THE CRISIS INTERVIEW

While the relatively healthy family is usually able to cope with crises as they normally occur in living, this is often not the case with families who have just begun treatment. Generally the therapy group can absorb many crisis situations, but family interviews are sometimes necessary to enable the family to resolve acute differences in relation to a specific problem. Family interviews are always offered, too, when continuation of treatment is threatened.

This was the case when Peter, the young man mentioned previously, stopped his private treatment after several months because his therapist insisted on payment of the fee which Peter had stopped after he had given up his job. Through a family interview at that point, it was possible to mobilize both Peter and his parents toward a mutually feasible financial arrangement which made Peter's return to therapy possible. Going beyond practical arrangements, Peter was encouraged to bring out his anger toward his therapist for making any demands on him, but then was faced with the reality that the therapist would not treat him without a fee. Following this family interview, in which the parents, Peter, and the two therapists participated, Peter secured a job and subsequently stayed in therapy for two years.

THE FAMILY INTERVIEW AS A TREATMENT TOOL

The timing of the family interviews described so far was determined by external factors. In contrast to this, the timing of other family interviews during the long stretch of actual treatment is motivated by our recognition that even though dramatic changes may occur for the individual or the couple in the group therapy situation, this does not automatically carry over into the family living and that certain deeply ingrained pathological patterns of family interaction tend to persist stubbornly. The family interviews held at fairly regular intervals give the family a chance to learn new patterns of interaction, made possible because of the already existing internal changes. Thus, the family interviews often serve the purpose of integrating the parallel group treatment processes into the family as a whole. It should be noted here that very often those members of the family who are not engaged in any other treatment participate in these family interviews.

One of the important dynamics in these family interviews lies in the fact that each therapist and his group client or clients represent a subgroup who have already shared a unique treatment experience with one another. This is utilized in the here and now of the family interview, thus giving their transactions a deeper meaning. Of great significance

also is the interaction of those participants in the family interview who do not usually work together, such as the therapist and those family members not in treatment with him and the two therapists in relation to each other. Finally, the participation of a family member who is otherwise not in treatment often brings to light aspects of family interaction which hitherto had not been apparent and were, therefore, unavailable for treatment.

The following illustration comes to mind. In an interview with the B. family—parents, adolescent daughter, and young son (the latter not in treatment)—the therapists noticed that the boy threw furtive and frightened glances at his older sister whenever a question was directed to him. He was clearly asking his sister, rather than his parents, for permission to answer. The parents, whose treatment had made them better attuned to the meaning of nonverbal communication, were also aware of this interchange between the siblings. The girl was reminded by her group therapist that she often shared secrets with one particular group member (the therapist had interpreted this as some indication of hostility toward her but had not seen this relatively harmless acting out on the part of the girl as overly significant). As the girl and her brother were confronted with the boy's apparent fear of her, the girl encouraged him to reveal some of the secrets between them. The most important secret was that she had seduced him into smoking, which she then held as a weapon lest he reveal her own "forbidden" (sexualized) activities with a boyfriend. To the great surprise and relief of both children, the parents' reaction was that no crime had been committed—a permissiveness that would not have been possible at the beginning of treatment. The parents' therapist associated the so-called secret with material which had emerged in the married couples group and reminded the father that he too "liked to play with fire." He responded with a boyish grin which, better than any verbal acknowledgment, conveyed that he understood. Thus far the parents had staunchly denied that the girl's pre-delinquent behavior and their own sexual life had elements of a forbidden activity and that some connection between the two existed. The experience in the family interview had a strong impact on the parents, who subsequently became more deeply involved in working on their own sexual problems and related areas of feeling and functioning. Similarly, the girl was profoundly stirred and shocked as she gained fuller awareness of her powerful hold over her brother, and she was able, for the first time, to experience a sense of guilt which had been markedly absent in the past. In the family interview a few months later, a marked shift could be observed in the family's equilibrium. The secret, sexually colored alliance between the children had greatly diminished; the boy now turned much more trustingly to his parents, as was obvious even in the changed seating arrange-

ments. The parents' earlier helplessness had turned into much greater acceptance of their parental role. The girl clearly was relieved that she had been permitted to give up a very burdensome power and that the parents now carried their rightful responsibility more readily.

However, family interviews during the course of treatment are not always experienced this positively by the children. We have had considerable experience with families who apply mainly because of predelinquency or active delinquency on the part of their children and they disclaim marital disharmony, a pretense which is taken over by the whole family. As these parents, through treatment in the married couples therapy group, gradually become ready to face the true nature of their relationship and become increasingly open about long-harbored feelings toward each other, this unfailingly finds its way into the family interview. Until this happens the child tends, in his own group experience, to maintain the pretense of the parents' "happy relationship." Efforts to help the child face the reality are frequently met with denial and anger, as though the therapist raising the question were a troublemaker. Underneath the denial of the child lies a fear of family collapse. When in the family interview the parents begin to talk openly about their marital conflict in the presence of the child, this can be often quite disturbing to the child, who may have been warding off awareness of this knowledge through escapist acting-out. The parents' acknowledgment that things are bad between them is experienced by the child as a bad dream come true, a confirmation of his underlying fear that the parents will separate. The child, to protect himself against these feelings, may start to reassure the parents, almost begging them to return to their former pretense. There is also a reaction of anger for being asked to be part of something which the child feels he should not witness. Yet, in spite of all these feelings, the child cannot help but sense something significantly different in the parents; things may be in a turmoil, but contrary to the previously maintained facade which made other outlets necessary, there is now an almost quiet acceptance of the problems between them which they must work on together. This indicates greater strength on the part of the parents, which the child does perceive on some level of awareness.

A recent experience with a girl who, a few months earlier, had participated in just this type of family interview illustrates that frequently some time is needed for the child to integrate into his life experience the initial shock engendered by the parents' admission of marital difficulty. Leah, the angry middle child mentioned in the first example, returned to the adolescent girls group after a successful summer away from her parents. Whereas in the past, Leah had powerfully resisted a deeper involvement, had tried

to use the therapy group as a social outlet, often interfering with its attempt to get into painful areas, she now appeared serious, related, and involved. She described her relationships with the family as markedly improved, stressing the mutual give and take and her feeling of a new respect for herself which she seemed to live out in the present family functioning. In contrast to her former amorphous family relationships and the feeling that the family was against her, she now realistically differentiated between its various members. She very movingly connected back to the family interview held several months before, talking of the great pain she had experienced as she witnessed her parents' expression of mutual deprivation. Leah's reference to an experience which had occurred some months back was particularly significant since Leah was a girl who could never "remember," claiming she could not hold on to feelings, had "forgotten" them.

An individual family interview does not necessarily lead to rapid, dramatic change, however. As pointed out earlier, certain interactional patterns tend to persist stubbornly in the family, impeding the development of its full growth potential even though marked individual changes have taken place in group treatment. Therefore, recurrent family interviews are necessary so that the family can repeatedly hear and see themselves in their interaction until new patterns of relating and responding are learned and integrated.

In this connection we have observed a seemingly paradoxical phenomenon, namely, the not infrequent failure of the child to respond more quickly to the genuine efforts and changes on the part of the parents. Indeed, it is the child who often seems to be perpetuating old patterns of relating, sometimes even acting in such a provocative manner as to almost dare the parents to revert to their old behavior. Several factors related to the therapist and the child seem to be involved in this. The therapist, in his desire to gain the child's confidence and hold the child in treatment, tends to ally himself with the victimized aspects of the child's functioning for too long, and thus prevents the child from taking responsibility for himself and his actions. Similarly, he can easily delineate what a child is exposed to at home but finds it much more difficult to identify those aspects of the parent-child relationship in which the child is the manipulator. To the extent that the therapist needs to act the perfect parent, he plays into the child's fantasy and undercuts the role of the parents. As far as the child is concerned, we are dealing with very complex psychological phenomena which may throw some light on why the child seems to expect most change to come from the parent. Firstly, psychologically, the child has a right to expect and receive nurturing from the parents. Where this was insufficient, profound feelings of deprivation and resentment accumulate, coupled with a deeply in-

grained image of the bad or weak parent which, because of its basic nature, tends to persist. The child cannot trust the change in the parent, especially since at best the change is inconsistent and tenuous for a long time. Furthermore, no amount of changing in the parent can approximate the child's fantasy of the perfect parent he would like to have. Last, but not least, the child's resistance toward acknowledging change in the parent makes it unnecessary for him to take responsibility for his active part in the family drama. The therapist's overidentification with the child serves to reinforce these resistances.

In this context, the family interview can be an invaluable tool whereby the child's therapist can integrate for himself the changes in the parents. As the therapist responds differently to the parents, the child finds himself momentarily isolated. Yet, where growth has taken place through the child's group therapy experience, on some level he really knows that he is holding back. Often, a light remark or joke by the therapist "calls the child's bluff" and enables him to let go of this piece of resistance.

However, it is not always that simple, as a recent experience of one of the writers with the D. family illustrates. The family interview included the parents (who were nearing the end of group therapy after lengthy treatment), their adolescent son, Robert, in treatment in a therapy group for adolescent boys, and the respective therapists. The father, a depressed, explosive man, had for a long time functioned near the panic level. He had behaved and been treated as the villain in the family, and a strong alliance had been formed between mother and son. Through group treatment and family interviews the wife gradually perceived her role as one which had perpetuated a pattern destructive to the entire family, especially to the boy. Significant changes had also occurred on many other levels, justifying the decision that the parents end their own treatment in the near future. It was felt, however, that Robert could make productive use of further treatment and should, therefore, continue his group therapy.

The child's crisis at this point became dramatically apparent in the family interview. He had to face the fact that his father had not changed into a happy-go-lucky fellow. As the mother, in contrast to her previous seductive alliance with Robert against the father, clearly carried herself as the father's wife and partner, the child was left with a sense that he had been deserted by her. This feeling was further accentuated by the parents leaving treatment together, with the expectation that Robert would carry responsibility for himself.

In the family interview Robert started out angrily, as he often had done in the past, contending that things were not good between him and his father and if his father was finished with treatment then he too was

finished. The father, whose treatment experience had been very painful, was shocked that Robert gave so little recognition to his real effort at reaching out to his son, and he responded with anger to Robert's maintaining the "old ghost." The father's anger had some of the old, explosive quality at first, almost justifying the child's claim that the father was still the same. A dramatic turn occurred, however, when the father, in a genuine encounter with Robert, spoke of the lack of full satisfaction in their relationship which he felt was partly due to Robert's refusal to take what the father was now ready to give, imperfect as it yet might be. With dignity, the father stressed his own need for and expectation of warmth from his son and firmly stated it was now up to Robert to do some of the giving. Recognizing Robert's jealousy of the younger sibling, the father pointed out that the younger son gave him affection and warmth and thus it was easier for him to respond. As the interview ended, Robert decided to continue in group therapy, and he and his father walked out of the interview with their arms around each other.

It should be mentioned here that when the therapy of the parents and children does not end at the same time, occasional family interviews are held to keep a channel open for the separate treatment experience to flow back into and be absorbed by the family.

FAMILY INTERVIEWS IN THE TERMINAL PHASE

Ending treatment is a process in and of itself, toward which the family and the therapists move together from the outset of treatment. Initially the therapist is felt almost as an intruder, as "alien to the family ego," so to speak. Especially where there are two therapists, each segment of the family tends to view with suspicion the therapist of the other segment as the latter's natural ally. Yet, we have found that a therapist's responses to the other therapist's clients can have a freshness and unbiased quality which often has the impact of mobilizing these clients even though the co-therapist's contribution may momentarily be felt as an unpleasant intrusion.

Early family interviews considerably facilitate the "incorporation" of both therapists as very meaningful figures in the life of the family, as the family increasingly gets the feeling that the therapists are on the side of growth. However, to the extent to which the family develops its own inner strength and finds a new, healthier integration, there develops the feeling that the therapist has outlived his usefulness and can now be cast off.

The separation process is naturally accompanied by anxiety and doubt as to whether the family can continue without help. This is often expressed by a temporary reversion to old patterns and panicky setbacks on the part of the family. It is important that the therapist not let this deceive him,

although this is not always easy for he himself is not omniscient and cannot feel entirely sure about the future. However, since the predominant feeling is one of trust based on much previous evidence of growth, the therapist's intervention in the ending phase aims largely at strengthening the family's sense that it really is capable of more adequately coping with the problems of living. As in any ending after a meaningful treatment experience, separation for both family and therapists is painful. Apart from the interpersonal factor, there is a need on the part of both finally to face the inherent limitations of treatment. The depth and finality of this knowledge mobilizes some individuals toward reaching even more deeply into their own inner resources to find ways which are uniquely their own and, therefore, truly creative. They cannot do this while the therapist is still someone to lean on, imitate, identify with, and to fight. This emergence of a final ego definition has been experienced by the writers a number of times at the point of the final family interview. Because of the highly personal, original quality of this self-expression, both family and therapists respond in an almost startled way, as if they were seeing this family-member in a new light. Interestingly, this seems to have happened more strikingly with fathers, and the writers conjecture that this may be related to the male attitude toward treatment. We have observed that men initially tend to resist treatment more than women, as if the experience of being recipients of help runs counter to their image of themselves as males. However, once the step is taken, the man often changes significantly, while still having a tremendous stake in bringing treatment to an end. He experiences a masculine revitalization when, at the point of ending, he can truly take over his role as the head of the family, with the rest of the family and the therapists recognizing and accepting this.

SUMMARY

In this paper we have shown how family interviews may be used in a variety of ways at various stages in the treatment cycle. The diagnostic family interview is held prior to the decision of placing some family members in separate therapy groups. The family interview in the course of treatment frequently involves all family members and always the two therapists, a fact which lends this encounter a special dynamic significance. Thus, while family interviews are used to mold together two parallel treatment processes and to integrate the changes achieved into the total family functioning, they invariably bring about something new for all participants which can be put to productive use in the respective therapy groups. Finally, family interviews are held at the conclusion of treatment as a way of heightening the family's and therapist's awareness of the changes that

have occurred and to return to the family its proper function of offering all of its members opportunities for further growth.

The early introduction of both therapists to the whole family serves to reduce each therapist's overidentification with and protectiveness toward his own client, which, to the extent that it exists, is frequently sensed and misused by the family and thus hinders growth. While we have not dwelled on the interaction of the two therapists, a subject which would go beyond the scope and limit of this paper, it must be noted that the co-therapists work as a team, with appreciable freedom in the use of themselves toward each other and the family.

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THE STRUGGLE FOR IDENTITY IN MOTHERS UNDERGOING GROUP THERAPY

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Identity has been conceived of as "a complex of psychic functions expressing the separateness of an individual and the awareness of this separateness as a specific ego function" (Beres et al., 1960). Manifestations of identity development are seen in id, ego, and superego development: in the id by drive expressions and gratifications, in the ego by "perception, reality testing, memory, identifications, object relations, and conceptualizations," and in the superego by the role it plays in self-esteem and self-evaluation.²

Mothers in group therapy at a child guidance clinic were found to manifest serious identity problems, such as: (1) a feeling of worthlessness, low self-esteem, and denial of the feminine role; (2) an inability to act independently with confidence; they had been unable to separate themselves from their own parents; and (3) an inability to form close interpersonal relationships even within their own family (husband-wife, mother-child). In all three of these areas, their behavior appeared to be largely guilt-instigated and accompanied by considerable underlying anger, resentment, and hostility.

The long-standing identity problems of these mothers stemmed from their original failure to establish a positive identity due to perceived rejection by their parent(s). The typical early ambivalent emotional attachment to the parent (primary identification) was greatly intensified. The degree of unacceptance these mothers were exposed to as children fostered intense anger and hostility, while the fear of losing what acceptance they did receive fostered a desperate attempt to love the parent in order to be loved. The anger over the rejection did not permit whole identifications, only partial ones and, thus, a fragmentary and incomplete identity conceptuali-

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² Other conceptualizations of identity have been elucidated by Erikson (1956) and Lynd (1961). Erikson gives identity a double direction, relating it to both the inner world and the outer world and stipulates the awareness of identity as characteristic of one stage of development and essential for maturity. He attributes multiple connotations to the identity concept—conscious and unconscious, individual and social. One of his connotations is that identity encompasses a conscious awareness of who one is. Lynd, in part building on Erikson's concepts, sees identity as a sense of significant self-respect. She postulates a feeling of shame (which implies an awareness of self and societal contradictions) which is transcended by pride in the sense of self-respect and which constitutes the foundation for identity development.

zation. In order to preserve some psychic integrity in the face of the perceived rejection, they utilized "identification with the aggressor" (A. Freud, 1946) and took on certain characteristics of the rejector. However, intense feelings of hurt over their rejection at times forced them to reject the rejector and, therefore, to reject part of themselves. They both loved and hated the rejector(s), and the resultant intense ambivalence became a prominent feature in their object relationships, as well as making it virtually impossible for them to introject a basically positive self-image.³ This identity-loss process is particularly acute in mothers who were in an only-child position and, consequently, had no sibling support against the parental rejection.

While the identity struggle appears to have its onset from the perceived parental rejection, this is followed by a cumulative re-enactment of the original identity loss with peers, spouse, and finally their own children. These people became recipient figures of the rejection object transference. There is a constant effort to re-establish the neurotic balance characteristic of the mother's childhood experiences (Durkin, 1954).

With marriage and later motherhood, there is identity dilution; they are then Mrs. X. or Mike's mother. Their anxiety over the perceived failure (child's symptoms) in the mother role is the culmination of the failure to establish a positive identity. Many really seek help for themselves under the guise of the child's problems, which are the embodiment of their own childhood conflicts.

The mother's anxiety over a lifelong struggle for identity is a feature of the disturbed mother-child relationship in three primary ways: (1) The mother relives her identity loss with the child through a hostile re-enactment of her own rejection. These mothers can allow only what was permitted them, and they unconsciously vent the anger they felt toward their parents for their rejection on the child. (2) The mother compensates for her identity loss through identity wish-fulfillment in the child. These mothers pressure their children to achieve and to behave so that they will win the acceptance they as children failed to receive from their parents. (3) The mother merges her identity with the child's, which expresses her separation anxiety over an anticipated identity loss. These mothers create

³ Another way of conceptualizing the identity struggle is via the shame mechanism, which Wallace (1963) sees as "a motive of defense in certain neurotic patients who have serious problems of identity." He distinguishes between shame as an ego function (conscious object relations) and guilt as a superego function (introjected parental relationship). He concludes, "Thus, the fantasy of being looked at in shame is considered to be primarily the fulfillment of a wish to be looked at and loved, along with a fear of abandonment, and secondarily a self-imposed punishment and confession in the pursuit of libidinal supplies" (p. 85).

strong passive dependency in their children so they will feel wanted and will not be unpredictably rejected. Each of these identity struggle reenactments have in common the fact that the mother identifies herself with the child in her attempt to solve the identity struggle.

In group therapy with mothers, the identity struggle is revealed in two overlapping processes: (1) the personal catharsis experienced in expressing their feelings about the relationship with their parents, and (2) the multiple transference reactions within the group. Some mothers fear the expression of anger, aggression, or hostility for fear of destroying what identity they do have, for they anticipate rejection as the result of their anger. This is based on the fantasy of the original rejection from their parents for "badness." Others fear the expression of positive, friendly, or tender feelings for they anticipate rejection of their "reaching gesture." They cannot risk an attempt at acceptance as they feel unacceptable. Within the group, the plea of the identity struggle is the reiteration of not liking themselves; which appears either directly in their verbalization and/or indirectly in their behavior toward and with other group members, which is necessarily transference-laden.

The following clinical excerpt exemplifies the beginning revelation of the identity struggle. Mrs. W. commented that Mrs. A.'s manner of dress had decidedly improved, that her hair was done and that she was wearing a fresh dress. (Previously she had appeared somewhat disheveled and spoke in a rather coarse manner.) The others complimented Mrs. A. too. Mrs. W. ventured to say that, prior to today, Mrs. A. had seemed like a "frump" and that this appeared out of keeping with the kind of person she seemed to be: intelligent, witty, and friendly. Mrs. A. seemed embarrassed, but pleased. When Mrs. W. asked why she took such poor care of herself, Mrs. A. openly stated that she did not like herself. She then went into detail as to how her mother had always been too busy to give her much acceptance, instead using her as a baby sitter while she was out partying. Mrs. A. felt resentful but stated that she loved her mother. She felt she was lazy like her mother, but, on the other hand, she felt she should always be home with her children. She would like to attend college night classes, but was concerned she would find this too interesting and would eventually be attending classes every night. Not to get out at all, however, made her feel a lack of self-fulfillment. (Her strong ambivalence toward her mother resulted in partial identifications and ambivalence toward her own identity). Mrs. L. wondered why they all so often seemed to act in opposite fashion to their mothers. Mrs. K. rather bitterly remarked, "Because we don't like how we are as the result of our mothers, so we don't want our kids to be like us." (Reject the rejector and thus reject part of oneself.)

Mrs. A.'s struggle for identity had many contradictions. To reject her mother for her rejection, she denies part of her own self-fulfillment. To accept the rejection and identify with her mother would lead her to act out her own rejection on her children (which she strongly defends against). From her "mothers" in the group she wanted the acceptance she did not receive but feared she would not receive it, so she prepared herself for and actively attempted to promote their rejection by her disheveled manner of dress. Her neurotic re-enactment of her own rejection with the other group members was the essence of her identity struggle. Mrs. W.'s unexpected acceptance and support was the beginning of a positive identification for Mrs. A.

As the group therapy progresses, acceptance from the parental transference objects (therapist, group members, or both) is the beginning of rebuilding positive identity. This occurs in three overlapping stages: (1) acceptance of the person as a worthwhile individual, (2) acceptance of their anger and hostility without retaliation, and (3) acceptance of their positive and tender feelings without rejection. In terms of the dynamic interaction of the group members, the process is essentially mother's experiential validation (Andrews, 1962) of her own worthiness. She is able to form a more positive, acceptable identity as the combination of the group members' support and defense confrontation permits her to understand her transference entanglements and adopt more appropriate relationship patterns. They reflect to her a more positive self-image which she is able to incorporate.

The following case resumé illustrates the struggle for identity of a mother in group therapy over an eighteen-month period. Mrs. S., an instigator in early sessions, was anxious, impulsive, and verbal. She usually started the sessions and always broke any silence. She presented herself as an angry, castrating woman. By the third month, she began to criticize the other women in the group and often acted as an ancillary therapist. However, she also began to act aloof at these times, frequently sitting at the far end of the table. Thus, she was both expressing her own feeling of unacceptableness (rejection of herself) and attempting to promote further rejection. This maneuver was followed by several absences. (In the early interaction, the group did not react to her with rejection so she herself withdrew to act out the anticipated and accustomed rejection.)

During the next two months, she launched into tirades about her husband for his lack of support. All males, she said, were passive and weak; she could not respect or accept them. (These were attempts to bait the male therapist into rejection of her for her hostility.) She competed with males, she remarked, because she did not feel very feminine (an early statement of her identity rejection). By the twenty-fifth session she was

openly hostile and antagonistic toward most of the group members. Mrs. S. spoke of her stepfather as weak and passive and of her mother as controlling the family with illness. She then brought out that she was illegitimate—her father had deserted her mother—and she said she felt inferior to others because of this. Her mother had placed so much emphasis on not being bad that she (Mrs. S.) felt she was bad. Mrs. S. always sat on the opposite side of the table from Mrs. R. and Mrs. G. toward whom she had strong negative transference feelings. Mrs. G. was like Mrs. S.'s mother, whiny, controlling and self-pitying, while Mrs. R. reminded Mrs. S. of her childhood neighbor who was constantly praised and openly favored by her mother. She felt Mrs. R. and Mrs. G. were "goody-goody" girls who sat in judgment of her "badness," so she sat opposite them on the "bad" side of the table. She tried to shock the other women with tales of bad thoughts and desires, mostly of a sexual nature. However, they soon became aware that these existed only in her thoughts and that she had never acted upon them. Mrs. D., in particular, emphasized that Mrs. S. was not bad because of what she thought, and she accepted Mrs. S. as good and worthwhile.

In these early months of therapy, Mrs. S. revealed that she could not tolerate acceptance from the other group members (mother-transference objects) or the therapist (father-transference object). She tried repeatedly to get them to reject her by bombarding them with the hostility originally felt toward her parents for their rejection of her. Her struggle for identity—whether she was an acceptable or unacceptable person—was re-enacted in transference within the group.

By the eighth month, her hostility toward the therapist was more open. This was related to her inability to get close to her husband. She clearly attempted to foster her husband's rejection, and she was trying to achieve the same ends with the therapist. (Both were re-enactments of the perceived rejection by her natural father.) With the group members, she was most hostile toward Mrs. D., who had begun to act friendly toward her, and she sat as far away from her as possible. (She rejects the anticipated rejector, but also expresses her unacceptableness; her hostility wards off the anticipated rejection, but also promotes it.)

The other mothers had been quite accepting of Mrs. S.'s hostility despite her continuous attempts to bait them into rejecting her. When Mrs. W. compared Mrs. S. to her mean, angry, and hateful child, several other women reflected this same image back to Mrs. S., but Mrs. D. significantly added that, if she knew Mrs. S. better, she felt she would like her. (They expressed acceptance of her hostility without retaliation.) Mrs. S. was rather puzzled by this incident, but during the next month she seemed much less

hostile and more sensitive to the others, often being supportive toward them. Mrs. R. and Mrs. D. commented on how changed she seemed, how nice she had become, and Mrs. S. denied it and seemed embarrassed. She stated that it was hard for her to think of herself as a "nice" person, that at times she was bad. (The group members acceptance was still unbelievable to her; she feared it would not last and slipped back somewhat to her old defensive position as protection against anticipated rejection.)

Near the onset of the second year of treatment, Mrs. S. focused on her sexual relationship with her husband. She saw this as a physical experience without any tender interpersonal feelings. Mrs. R. suggested that Mrs. S. was missing the real meaning of sex and that perhaps Mrs. S.'s husband couldn't accept her because she did not allow any real close feeling between them. Mrs. S. exploded in anger at Mrs. R. and called her a phony, but at the height of her anger, she broke down and cried for the first time in the group. She said, "This is ridiculous. It's a sign of weakness." The other group members did not see it that way and accepted her feelings. Sobbing, she said Mrs. R. always disagreed with her. Mrs. R. firmly responded that Mrs. S. had never let her agree by being so hostile and had rejected all her compliments. She then added that Mrs. S. seemed to use anger as a defense against letting people get close to her. After this episode, Mrs. S. was a more tender person. There was some expression of doing things for others by pouring coffee for them. (In this period her primary defense was confronted, while her tender feelings were accepted without rejection.)

During the eighteenth month, Mrs. S. talked about her conflict over her son's desire to go to camp: "He has never wanted to go before." (He was in an activity therapy group and had matured enough to be able to separate from her with confidence.) She did not know whether she could let him go. Her associations were that his prior complete dependence on her made her feel wanted and needed and that if he went away, no one would need her. (This was identity submersion by Mrs. S. to handle her separation anxiety and represented her neurotic attempts to maintain some identity. Her parents separated themselves from her by their rejection.) The group members helped Mrs. S. to bring out the feelings which expressed this, and several weeks later she announced that her son had gone to camp. She felt proud, and the others congratulated her on her progress. The group both helped Mrs. S. to open up avenues of insight and provided the nurturing ingredients for her identity development in their acceptance of her. She could break the neurotic attachment to her son as she accepted herself more and began to build a positive identity. He was no longer necessary to her struggle for identity.

CONCLUSIONS

The enactment of intragroup transferences is both the manifestation of and the initial move toward the solution of the identity conflict. The neurotic nature of the rejection re-enactment within the group is highlighted through progressive illumination of the transference reactions, which gradually diminish as the therapy proceeds. This permits the other group members' acceptance and support to have its full impact and opens avenues for identification.

Scheidlinger (1955), in discussing Freud's concepts of identification, described "secondary identification" as involving "the replacement of a discarded object-cathexis with another object which is set up within the ego," adding that "such a regressive introjection is often considered a defense mechanism which is utilized as a means of dealing with the loss of an object." In mothers with identity problems, the group members and the therapist are sources of secondary identification most basically in that a mother is able to introject the positive self-image which they reflect to her as a replacement for her earlier rejection by her parents (object loss). She can identify with the accepting "mother" and/or "father" in the group and, therefore, becomes able to accept herself and others with equanimity. This process is akin to Slavson's (1950) "identification transference," whereby attitudes and relations are derived from identification with other group members and are stimulated by the group members' acceptance of the member in three overlapping stages: (1) acceptance as a worthwhile individual, (2) acceptance of anger and hostility without retaliation, and (3) acceptance of positive and tender feelings without rejection.

In terms of a theoretical model, the group members and the therapist recreate the "family situation" in which the old rejection pattern is first re-enacted and then, through transference analysis and extensive emotional support, they gradually reverse this pattern toward self-acceptance. A healthy repudiation of an unacceptable self is followed by the awareness of an acceptable self. The negative and inadequate primary identifications of childhood (based on parental rejection) are replaced by positive and acceptable secondary identifications (group members' acceptance and support). The mother is able to validate her worthiness by actual experience within the group. Her identity is then based upon a positive, acceptable self-awareness.

Lynd (1956) has succinctly summed up what I feel is the cardinal value of group therapy in the struggle for identity in stating: "As one finds more relatedness to other persons, one discovers more of oneself; as the sense of one's own identity becomes clearer and more firmly rooted, one can more completely go out to others."

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SPECIAL PROBLEMS OF RESISTANCE IN CO-THERAPY GROUPS

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The use of co-therapists in group psychotherapy has attracted increasing attention during recent years, perhaps because, as Gans (1962) has stated, it provides an effective short-cut for the training of group therapists. Co-therapists have applied their skills to various types of group therapy situations. The use of dual leadership has been represented as socially familiar and representing understandable cultural authority for the aged by Linden (1954), for groups of adolescents by Boenheim (1957), Kassoff (1958), and Adler and Berman (1960), and in the application of a family-oriented approach to a disturbed child by Belmont and Jasnow (1961). In working with groups of psychotic and schizophrenic patients, similar observations were made by Lundin and Aronov (1952) and Orange (1955). Cameron and Steward (1955) utilized co-therapists in group therapy with chronic psychoneurotic patients in a mental hospital. Co-therapy work with clinic patients, mainly neurotics, was described by Hulse *et al.* (1956).

Many of the articles about co-therapy groups emphasize the differences they present from single-therapist groups, the special problems encountered, and consequences arising from the differing personalities of two therapists. Most authors find greater evidence of parental transferences with co-therapists than with a single therapist. Studies of the roles, sex, and transference relations to parental figures in co-therapy groups have been described by Demarest and Teicher (1954). A few authors mention some special problems, and some disadvantages are noted by Slavson (1960) in the discussion of the article by Adler and Berman (1960). Solomon, Loeffler, and Frank (1953) describe the co-therapists' interaction as nurturing both the therapists and the group. Understanding and awareness of countertransference was pointed out by Mullan (1955) to be more readily discernible in co-therapy groups because the difficulties of each therapist can be noted by the other.

Scant attention has been paid to the problems of resistance in co-therapy groups, and only brief allusion to it appears in the literature. Possibly this is because of the relative newness of the technique. In our utilization

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of co-therapy, we have found that problems of resistance not only occur just as they do in all forms of psychotherapy, but also that resistance may take forms not encountered in single-therapist groups.

The special types of resistance which arise with co-therapist groups are related to the presence of a second therapist. In general, these resistances take two main forms: (1) the use of one of the therapists to avoid problems and to limit and deflect emotional relationships by the mechanism of identification; (2) the abuse of one of the therapists in order to repress and suppress other emotions, and the playing of one therapist against the other in order to maintain character patterns by the mechanism of projection.

These resistances are usually manifested in one or more of the following ways: (1) unfavorable comparison of co-therapists; (2) making a scapegoat of one of the therapists; (3) assuming the role of a therapist; (4) using a therapist to perpetuate symptoms; (5) avoiding relationships with patients of the "other" therapist.

Examples of these types of special resistance problems in co-therapy groups will be described with case illustrative material.

UNFAVORABLE COMPARISON OF THE CO-THERAPISTS

An extremely narcissistic patient always said one of the therapists was cold to her or bored with her. She talked excessively, giving lengthy descriptions of sexual perversions, and frequently indulged in coarse and vulgar language. Her exposition of her difficulties served as a means of constantly maintaining the center of the stage in the group.

She played on the therapists by first saying that "her" therapist in the group was not giving her any attention. Then she would subtly compare the co-therapist to her former individual therapist whom she described as very kind, warm, and loving. Early in therapy the co-therapist responded to her often with interpretations and warm acceptance.

The patient persisted in this behavior, self-pityingly announcing at many sessions that she felt ignored by her therapist and that he had erected a wall against her. In time, even the warmth and acceptance of the co-therapist were distorted, most often at a subsequent session during which she would complain that he was treating her difficulties lightly or that he was taking an opposite position from her.

In the course of postsession summaries and pre-session reviews, the group therapists decided that this patient might be helped if she could learn to realize that she could not have the therapists' (father and mother) attention so frequently. Thus, in later sessions, as she talked, the therapists did not interact with her. Soon the other group members picked up this

clue, and they began to interrupt her and to challenge her excessive talking. The patient became very angry in her comments. She also called the therapist frequently between sessions, complaining of her treatment by the group.

After the eighty-fifth session, the patient suddenly announced that she felt good and was going to leave the group. Six of seven patients remained silent, but one of the patients and one of the therapists told her to reconsider her position. The patient did leave the group, but returned after a three months' absence, saying that she had realized that she needed more help. Again the group reacted with some silence and some antagonism. The dissenting patient and both therapists welcomed her return.

After her return the patient gradually assumed a less narcissistic position, becoming a listener instead of a talker who dominated the sessions. To a large extent, she discontinued playing one therapist against the other. Soon she resolved to see if she could not get satisfaction from situations as they developed instead of protruding herself into frustrating cycles of attention-getting which only resulted in more demands for more attention. This patient was discharged improved after two and one-half years of group therapy.

This case description demonstrates that unfavorable comparison of therapists by a patient is a resistance to be dealt with by the co-therapists acting together. In letting the patient know by their similar common interaction that unfavorable comparisons will not be helpful, the therapists create an atmosphere which permits the patient to overcome this resistance.

MAKING A SCAPEGOAT OF ONE OF THE THERAPISTS

When scapegoating occurs in groups with one therapist, it is directed against one of the patients, but in co-therapy groups the patients may gang up on one of the therapists whom they feel is threatening their resistances.

About the fifteenth session in a group composed mostly of formerly psychotic patients with residual personality disorders ranging from severely paranoid to extremely inadequate, one patient challenged the co-therapist's alleged statement that the group was not allowed to socialize. The co-therapist's denial of having made this statement was discounted, and the patient group proceeded to vote unanimously that the co-therapist had made such admonitions. The heat of the attack against the co-therapist was so great that it was almost unendurable.

Five of the patients of this group of seven clandestinely sought out another therapist and asked him to take over the group. Their main complaint was that we had allowed two of the patients to become intimate. This seemed ironical and contradictory in view of their scapegoating vote

that one of the therapists wished to prohibit socialization. The group therapist who was consulted refused to take over the group. He told them that we were experienced therapists and that they were behaving like errant children.

The five returned to the following session but now directed their scapegoating against the intimate couple. At the next session the co-therapist actively intervened, saying that the group could not conduct a kangaroo court. He stated his position firmly that ganging up on individuals was anti-therapeutic and that no one was to be attacked by vote or by agreement at secret meetings outside the group.

From this session on, scapegoating practically disappeared, although excessive hostility was still expressed for many sessions against the co-therapist and the intimate couple. The therapists, working together, directed the patients to their fears of intimacy and their jealousies about heterosexual relationships. Although it was a very stormy period of working through for the group, only one of the scapegoating leaders dropped out of therapy.

Scapegoating is a form of group paranoid projection. When directed against one of the therapists, it indicates that the group feels they have to attack the therapist who, in their opinion, is not accepting of their habitual modes of relatedness. The co-therapist had actually stated on two occasions that we could not control their social existence. Apparently, the freedom and intimacy implied in his statements was more than the emotional life of these patients could tolerate.

Both therapists realized later that it would have helped the group had they not permitted the scapegoating vote in the first place and had they redirected the hostility earlier instead of allowing it to get so far out of hand. Hindsight, however, is easier than when working with the turmoil and pent-up feelings at the time. The recognition of scapegoating of a therapist as a resistance to be firmly dealt with in co-therapy groups is very helpful in overcoming group jealousies and mistrust.

ASSUMING THE ROLE OF A THERAPIST

In single-therapist groups, when a patient assumes the role of the assistant therapist it is quite readily discernible. In co-therapy groups, however, because one of the therapists is more passive than the other or both therapists are simultaneously passive at times, a patient can more readily assume the role of therapist, co-therapist, or assistant therapist without prompt detection.

A female patient, who had a very quiet demeanor with a warm, sympathetic, friendly tone to her voice, was very fearful of hurting other peo-

ple, and even more fearful of being hurt because of her own feelings of inadequacy. In group sessions she would draw out other patients during silences, and if a therapist spoke she would very neatly take over or continue or reinforce his comments. Her technique for avoiding her own problems was to say, at the very beginning or toward the end of a session, "I have a problem." She would mention some personal matters superficially, get some minimal interaction, and quickly say, "Now I feel better," and then she would promptly resume her therapist role, guiding, asking questions, and encouraging the patients in the group.

The group, which was made up of young people, found this patient quite helpful to them and did not challenge or question her behavior. Her behavior fitted their wish to avoid involvement with parental figures. They looked for ways of discussing their problems of love and aggression, sex and identification, but tried to avoid interaction with the therapists. It was youth finding its own way. But on a dynamic level, it was a subtle rebellion against the therapists in order to resist working through their feelings of dependence on their parents, and the additional "therapist" in the group furthered this resistance.

Often during sessions the assumed therapist and group members carried on as though the therapists did not exist. Or one or the other of the patients would speak up to nullify or divert any meaning or interpretation coming from the therapists. The therapists began to question the behavior of the patient acting as therapist, and eventually she was helped to overcome her fears of hurting and being hurt.

The role of assistant therapist is not usually as effectively played as it was in this young people's group. Although the reasons for this primarily concern the personality of the patient taking the role, the reactions of the group members, their own defenses and resistances, also account for the acceptance or rejection of "still another therapist" for the group.

USE OF A THERAPIST TO PERPETUATE SYMPTOMS

An obsessive phobic patient joined an already-existing group, and for session after session dominated the hour with talk about her fatal diseases which would soon cause her demise. She played upon the sympathy of one of the therapists, who interacted with her about her phobias. To the group and the other therapist her symptom recitations and her perpetual prediction of death began to wear quite thin. The group therapists discussed the matter and agreed that she would be gradually diverted by both therapists from her obsessive phobic illness preoccupations. Although the process has been gradual, this has helped the patient and the other group members.

In another group, a paranoid patient spoke about males who dominate the universe. She would address herself to her own therapist as if they had a lifelong agreement that she was right and that she could talk endlessly on this subject. She would use various nonverbal appeals, such as offering him a cigarette or asking him for a light. If another patient talked, she would proceed with her own compartmentalized ideation and interrupt at any time about how males controlled the world. The therapists agreed between sessions that they would interrupt her and ask other patients to talk. Since this only helped temporarily, the therapists asked her to listen more. Although she tried to do this, she could not tolerate the position of a listener. After discussions privately with her therapist, it was agreed to discontinue all psychotherapy. Both therapists felt that this patient had attained some degree of adjustment and that therapy, individual or group, was helping to perpetuate her difficulties.

The use of the therapist to perpetuate symptoms does occur in individual psychotherapy and in group therapy with one therapist, but this resistance is more obvious with co-therapists because the habitual mode of using one of the therapists is readily apparent to the "unused" therapist. The unused therapist can actively question what is going on which might otherwise be obscured by the transactions of the patient and the other therapist. Transference reaction patterns of the past which are projected onto one therapist may be more difficult to deal with when the therapist is not aware that these patterns are being used as a resistance to perpetuate symptoms of the past by evoking sympathy, obtaining reinforcement, and implying connivance of a therapist by participating in psychotherapy. The co-therapist is in a better position to question such a use of therapy.

AVOIDING RELATIONSHIPS WITH PATIENTS OF THE "OTHER" THERAPIST

In groups with a single therapist, all the patients are seen as siblings. However, in co-therapy groups some patients react to the others as though they were stepchildren or even nonparticipating observers who happen to be there because of the presence of another therapist (stepparent?).

A patient who had a great deal to say in the group when his own "siblings" participated claimed that he had no feelings in common with the other patients, and even objected to being in a group with patients placed there by the other therapist. In his workaday world he had great difficulty with his personal relationships, often complaining that he could not make friends and that he always met rejection if he tried to form relationships. The therapists met his resistance by guiding his interactions in the group and stimulating his interest in the patients of both therapists.

In another group the patients admitted rivalry toward their own thera-

pist's patients but denied similar feelings toward the other patients, stating that it was a problem for the other therapist and his patients.

A thirty-five year old white married female came to a first group meeting and expounded her problem of delusional jealousy. She prodded the other females to talk about their husbands and their jealousy problems in the first session. The other patients were very reserved as she took over.

The next day she called and said she would not return. She complained that the group members were there, not to be helpful or for therapy, but in order to get her to leave her husband. In an arranged individual session she complained that the patients were not understanding because they were not patients of her therapist. In fact, she was not even sure of their therapist's motives in having them there. She discontinued all therapy, but after one year returned to individual therapy, at which time her problem of relationships with the other patients was discussed and she returned to group therapy.

Although the resistance of avoiding relationships with patients of the "other" therapist occurs in all co-therapy groups and is significant, it does not assume the proportions nor create the difficult problems encountered with the other forms of resistance. However, for any one patient it may be a very difficult problem and one which causes him to drop out of therapy. It can be handled by the interaction of the co-therapists with all the patients and by their guiding and stimulating interaction among both sets of patients.

COMMENTS

Special problems of resistance occur with co-therapy groups. It is not within the scope of this paper to compare the effects of these resistances with those that occur in groups with one therapist. However, the working-through of resistances is an integral part of dynamic psychotherapy and working through these special resistances in co-therapy groups expedites therapy just as it does in groups with a single therapist or in individual therapy.

The shield of resistance in groups with co-therapists is of the same defensive nature as all resistances. Whether it is to be ignored or attacked, undermined or circumvented, discussed and analyzed is for the co-therapists to decide before action of any kind is undertaken. Here a greater opportunity exists for understanding and appreciating the individual and group effects, because each therapist can serve both as sounding board and a check for the reverberating effects of the working-through of the resistances.

In this paper the position and role of each of the co-therapists in spe-

cial resistance problems has been described. An awareness of these roles and positions into which a patient or group places one of the therapists contributes to understanding the therapeutic process. Patients and groups ascribe to and bestow upon co-therapists polar attributes and characteristics which are positive or negative, distorted or valid, benign or malign. These are not only differences in the personalities of the therapists, transference relationships, evaluations and judgments, or deficiencies or problems in the therapists. Previous writers have stressed such differences perceived in co-therapists but have not related these appraisals by patients to factors of resistance. Our experience tends to emphasize that patients and groups exploit these differences between therapists. The continued exploitation of differences to impede progress in therapy is the core of the special problems of resistance with co-therapy groups.

In general, patients relate to therapists or react to them in terms of identification or projection. By means of the mechanism of identification the patient is usually serving his ego in adjustable ways to establish new patterns of behavior. However, continued and repeated use of the therapists in this manner suggests: (a) unfavorable comparisons between the therapists, (b) assuming the role of a therapist, (c) using one of the therapists to perpetuate symptoms. These identification defenses may become a resistance to therapy.

By means of the mechanism of projection, usually accompanied by hostility, the patient is establishing some basis of relating to figures which constitute threats to his previous modes of adjustment. Many patients work through this mode of adaptation with less and less need for hostility and projection. However, repeated abuse of one of the therapists may continue in the form of: (a) using one of the therapists as a scapegoat, (b) unfavorable comparison of the therapists, and (c) avoiding relationships with patients of the other therapist. These projective defenses may become a resistance to therapy.

SUMMARY

Special problems of resistance occur in co-therapy groups. Case illustrations of their development with five representative types or examples are outlined. In groups with dual leadership, patients may use by identification or abuse by projection one of the therapists. Although the differences which are inherent in two human beings are to be expected in co-therapists, the repeated and continued exploitation of these differences by group members should be regarded and treated as resistance when it impedes the progress of therapy of the individual patient or the group.

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BRIEF COMMUNICATIONS

SOME COMMENTS ON TRANSFERENCE WHEN THE GROUP THERAPIST IS NEGRO

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When the therapist is Negro (and the patients are white), certain important dynamic and economic factors are introduced into the already complex inter- and intra-psychic processes. The very fact of the therapist's being a Negro can motivate symbolic processes, fantasies, and fears in the patients which can have crucial effects upon the manifestation of the transference—as it is related to resistance and working-through; and to the countertransference—as it is related to the Negro therapist's own self-image and his reactions to the patients.

A few examples must suffice as clinical background. A group composed of neurotic patients, with whom the Negro therapist had been working for a few months, had spent the hour discussing the subject of their responses to authority. Throughout the interactions, there had been numerous references to "black" (e.g., "... the black shadow of authority . . ."). At the end of the hour, the therapist referred to the generality of the discussion and wondered if the group had not spent the hour avoiding some important issues. In the activity of adjourning, the therapist heard a patient's whispered comment: "Oh, Oh, the black God is out after our resistance." On another occasion, a schizophrenic patient stimulated laughter in a group of similarly diagnosed patients by referring to the therapist as "Booker T. Freud." At another time, a schizophrenic patient, admonishing herself for being unable to tolerate her "suffering," said that she felt ashamed to face the therapist for "you and your people have known true suffering."

These examples are instructive in the sense that the first is a clear expression of resistance; the second, an example of some degree of positive regard for the therapist (the compounding of two famous men), while, at another level, the patient's tone of voice and the collective laughter suggested individual resistance, as well as "group resistance." The third example is a maneuver to frustrate attempts at working-through by overinflating the therapist's tolerance for suffering, associating him with the myth of the Negro's tolerance for suffering.

It would be theoretically incorrect and clinically unsound to argue that the dynamics of the psychotherapeutic process are not affected by the therapist's being a Negro. The cultural and value orientations of the patients are to be taken into careful consideration, as well as the Negro thera-

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pist's countertransference reactions to them, no matter how deeply repressed or carefully suppressed either may be. When the therapist's race becomes the point of departure for an "attack" upon him by an individual patient or the group, it constitutes a source of great resistance, even though the patients' cultural and value orientation may designate "attacks" on Negroes as well within normal limits. The patients may be unable to overcome ego and superego resistances (Spotnitz, 1952²) stimulated by mythical and symbolic elaborations upon the meanings extracted from the emotionally laden symbol: "Negro." These meanings have extremely archaic, unconscious roots. Although not discussing the specific question of race, Peto (1959), in his considerations of body image and how patients confuse the therapist's whole person in terms of good and bad, love and hate, offers some valuable insights for this discussion. The meaning of "Negro," in a magic-symbolic sense, usually associated with "badness," "inferiority," and emotional abandon, may be an imago which *can* be integrated into the patient's ego without threat, although the very integrating then stimulates resistance.

The Negro therapist will find that the forms of resistance that do manifest themselves will be very difficult for he and the patients to work through, primarily because the resistances are never related only to neurotic bias or prejudices but to certain reality factors and socially acceptable patterns of interracial interaction, as well as to archaic, unconscious forces which impede and/or block the manifestation of the transference. These types of resistance may be profoundly related to character traits and/or ego defenses which the white therapist would not hesitate to analyze (Durkin, 1951).

The Negro therapist will find himself dealing not only with ego and superego resistances, but he will have to be prepared (emotionally) to deal with a type of "sociocultural, characterological" resistance stimulated by the very reality of his being Negro. This complex situation can, because of the "regressive pull" inherent in it, stimulate great anxiety in the therapist (especially if he harbors neurotic and/or counterphobic reactions to his own race) and in the group (especially if they become aware of these reactions in the therapist). The resulting interference with communication between therapist and patients will be disastrous for group psychotherapy. Detecting these points of insecurity in the therapist, the patients will put him to painful tests. On the other hand, patients sometimes avoid and/or deny the racial factor (perhaps to protect the therapist); or, they may so completely accept his race (as not being within the limitations of the therapeutic contract) that they do not find it necessary to block when using well-known idiomatic expressions such as "nigger in a wood-pile" or "faster than a scared nigger." Such metaphoric expressions *can* be used, in the context of the group's verbal exchanges, without the slightest reference to racial

² It is obvious that the theoretical references cited do not consider the race of the therapist as a parameter producing variance in the theoretical model.

prejudice or bias on the patients' part and without stimulating narcissistic mortifications (Eidelson, 1959) in the Negro therapist.

The reality fact of the therapist's race is a "situational exigency" (Heilbrunn, 1958) which must not be allowed to become interlaced with the patients' conflicts which brought them to therapy in the first place. But if it does occur, the patients' hypercathexis of a reality situation can constitute a form of total, insurmountable resistance which can serve (1) to isolate the emotional problems from the patient-therapist relationship and (2) to stimulate severe acting out (Heilbrunn, 1958). In the supervision of and consultation with the Negro therapist, these issues must be given very careful study.

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GROUP PSYCHOTHERAPY IN THE TREATMENT OF ACUTE EMOTIONAL DISORDERS

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In the past decade the number of psychiatric treatment units in general hospitals has increased considerably. There are distinct psychiatric, humanitarian, and sociological advantages in this development. Prompt treatment in a community hospital often prevents the disruption of the family which occurs when the patient is hospitalized at a distant state hospital. Present treatment methods may be more effective at the start of emotional illness than after an abnormal behavior pattern becomes fixed. Intensive brief hospitalization may also prevent the severe regression and the devel-

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opment of strong dependent attachments to the institution that often hinder the progress of the patient.

The initiation of a group psychotherapy program on the Acute Treatment Service at The Langley Porter Neuropsychiatric Institute provided an opportunity to study the use of group psychotherapy within the framework of brief-term, intensive hospital care. This paper is a report of our experience in working with these groups and in the training of psychiatric residents during the first half-year of the program.

Four residents were assigned to the 26-bed inpatient ward of both male and female patients, which usually contained a few more women than men. The patients, about half of them psychotic, ranged in age from 14 to 80. Their hospital stay varied from two to six weeks. Psychotherapy, social manipulation, and somatic treatments were often combined in the treatment.

ORGANIZATION OF THE GROUPS

Each psychiatric resident met with his six patients from 9:00 to 9:30 every weekday morning. The groups convened in separate rooms with the chairs in a circle. Initially the residents perceived their role as that of a helper and a catalyst, and they tended to let the group follow its own volition. However, with experience they used more structured techniques.

The acutely disturbed patient was included in the group the morning after his admission. To our surprise we found that acute patients, many of whom had a history of violent behavior, could enter a group at once. The psychotropic drugs facilitated the speed with which the individuals entered the groups, but equally important was the social structure of the unit, which conveyed to the patients an expectation of normal behavior. They were treated as individuals and rational adults. This message and the social forces behind it quickly shaped the patients' behavior.

OBSERVATIONS OF GROUP PROCESS

1. Commonly, the patients in the group were surprised that the person next to them had experienced many of the same difficulties. He, too, had heard voices accusing him of foul and abnormal acts. Thus, the patient learned that his symptoms were not unique, knowledge that was an important factor in alleviating acute anxiety.

2. During the meetings the patients saw behavioral changes in the group members, some of them very dramatic. Not uncommonly, within several days a hostile, biting, paranoid became active and cooperative. Patients used the experience of watching such changes to modify their own behavior.

3. Within one to three sessions the patients became so involved in the group that they were upset if the meetings were late or were cancelled. This rapid attachment to the group, along with the rapid formation of

jealousy among the group members, was striking. Patients were seen individually as well as in the group, and the jealousy may have come from a reconstruction of early family conflicts.

4. Catharsis occurred in the sessions and was helpful to the patient. However, an occasional verbalization in a patient with hysterical character structure turned out to be one more form of manipulation.

5. The groups developed an *esprit de corps*, and the members were protective of and helpful to their colleagues during other ward activities. Nursing supervisors reported that these patients were more gregarious and considerate of one another than were the usual patients.

6. Interactions within the group gave members an opportunity to develop not only psychological knowledge but also social skills, which many of them lacked. General problems, such as, "How do I deal with my boss?" and "What shall I tell people about my illness?" were considered, and the discussions proved helpful.

7. The groups were a slice of life in which each patient behaved characteristically. The inadequate individual behaved inadequately; the paranoid was suspicious, the hysteric manipulative. The patient dealt with his conflict by living it out with other group members. Since many of the patients had poor verbal ability, this opportunity to show them something real—what was happening between them and Mr. Jones—was perhaps the most important therapeutic tool. The therapist worked with the irrational elements of conflict, not in the form of fantasy, but in the forms projected onto the social scene. This could be done best in a structured manner, using concepts derived from ego psychology or from "transactional analysis" (Berne, 1961).

OBSERVATIONS ON RESIDENT TRAINING

Initially, the suggestion to investigate the use of group psychotherapy as a therapeutic tool with acute patients was met with considerable opposition. Most of the personnel had had little experience with groups and felt that group therapy would not benefit the acute patient. Six months later the residents realized that group therapy was a valuable and integral part of the ward program. They would not tolerate the removal of a patient from the morning meeting for routine studies, and they called for increasing amounts of group work.

1. The morning groups provided the residents with a valuable educational experience. The residents, as a result of being in the midst of a difficult and interesting endeavor, found group psychotherapy a challenging and useful addition to the psychiatrist's armamentarium.

2. The inexperienced resident often overestimated the patient's pathology in individual interviews. Sometimes the interactions in the group revealed strengths within the patient that the resident had not been aware of, and the additional information gave the resident a more complete picture of his patients' abilities and liabilities.

3. Transactions within the group quickly revealed the patient's individual personality characteristics. Although the residents were reluctant to tackle these problems therapeutically in the group situation (perhaps because of inexperience), they made excellent use of the material in planning the long-term treatment of the patient.

DISCUSSION

At first, the residents conducted the sessions in nondirective fashion, and many of the meetings went poorly. They found techniques borrowed from the psychoanalytic model were misapplied when used with these disturbed patients. The group would consistently respond only if the therapist took the responsibility for getting things started, brought up matters that ended in impasses if left unsaid, and actively and clearly entered into the group process (Artiss, 1962).

The patients were hospitalized for the express purpose of modifying behavior which prevented them from living with their families in the community. Compared with other therapies, group psychotherapy based upon ego psychology seemed the therapy of choice with these patients. A group permits behavior patterns to develop in a real-life manner. Defective defense mechanisms can be examined and perhaps discarded. In the group social environment, strengths can be utilized and other ego skills developed.

In the brief treatment situation, where the emphasis is placed upon reintegration and re-education, group therapy offers several advantages over individual psychotherapy:

1. The relationships in a group tend to be more influenced by reality. Dependence and regression are not fostered to the same degree as in a one-to-one relationship.
2. The multiple interpersonal relations allow for displacement, diversion, and dilution of transference emotion.
3. Magical expectations and omnipotent struggles are restricted.
4. The therapist can work with the irrational elements of conflict, not in forms of fantasy but in forms projected onto the social scene.
5. A nutrient milieu permits important educational experiences to occur. In many of our patients, the primary problem was not regression from a functioning level but a massive lack of social and life skills. With these patients, the educational aspects of the group may be the outstanding therapeutic contribution.

One might speculate on the advantage of organizing the psychotherapeutic efforts of acute treatment wards about group, not individual, psychotherapy. Some of the reasons for such action have been described. There is a great need for further investigation in this area.

SUMMARY

Group psychotherapy was used in the treatment of acute emotional disorders. The patients' actions and verbal reports support the efficacy of

this form of treatment. It was found that the therapist should be active in these groups, that structured techniques should be used, and that interpretations should be based primarily on pattern analysis and analysis of interactions. The evidence suggests that use of group psychotherapy facilitated the goals of brief-term hospitalization.

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BOOK REVIEWS

Edited by BERYCE W. MacLENNAN, Ph.D.

MINUTES OF THE VIENNA PSYCHOANALYTIC SOCIETY, VOL. I, 1906-1908.
Edited by *Herman Nunberg* and *Ernst Federn*. New York: International Universities Press, 1962, 447 pp., \$10.00.

The first volume of the Minutes of the Vienna Psychoanalytic Society allows one to re-experience the excitement that must have existed in this initial group. It is true that the Minutes are not easily understood; some papers are rendered in a form too abbreviated, while others are mentioned only by title. Otto Rank, who was the permanent paid Secretary, seems to have taken extensive notes of the discussions and edited them later. The contents of the discussions are expressed with remarkable lucidity.

These Minutes are the record of the Wednesday evening meetings from 1906-1908 which were regularly held in Freud's own apartment. The earlier Wednesday evening meetings, also held in Freud's apartment, during 1902-1906 were known as the "Psychological Wednesday Evenings." No records are available for this period. We know, however, that this period was occupied with a study of the many important articles and basic books which Freud had already published. In 1908 the Vienna Psychoanalytic Society was formed and the Meetings became a function of the Society.

These weekly meetings were suggested by Dr. Wilhelm Stekel. Their aim was to discuss psychological problems. The group was heterogeneous and consisted of physicians, educators, writers, artists, and others, representing a cross-section of the intellectuals of that period. They were all different in background and personality but were held together by their discontent with the conditions that prevailed in psychiatry, education, and other fields dealing with the human mind. We can assume that the urge of these men to understand and heal their fellow men reflected their own needs for help. On the one hand, this group was in search of new ideas and of a leader; on the other hand, Freud was a lonely man who had made important new discoveries and wished to share them with others.

The reader of the discussions readily becomes aware that the discussants had not yet acquired wide psychoanalytic experience. He finds much guesswork and many premature statements being made. These discussions were spontaneous, unprepared reactions to papers heard the same evening.

These early followers considered themselves pupils of Freud and for a while worked with him in harmony. We readily become aware, however, that this harmony did not last very long before ambivalence began to exercise a negative influence. We see factions and rivalries develop, accompanied by quarrels of priority and competitive attitudes which manifested themselves even toward Freud.

The membership of the Society grew steadily and the discussions became more substantial and better organized. The development of ideas can be followed as they slowly took on definite shape, and we are able to watch the steadily growing stature of some personalities.

This first volume deserves careful reading; all the Meetings are replete with valuable information. The editors have exhibited excellent workmanship and given intimate glances into this original group as it worked and evolved under the directing genius of Freud.

SAMUEL ZACHARY ORGEL, M.D.
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COMMONSENSE ABOUT PSYCHOANALYSIS. By *Rudolph Wittenberg*. Garden City, N.Y.: Doubleday, 1962, 296 pp., \$3.95.

This is a straightforward, well-written book which sets forth the theory and practice of psychoanalysis according to the classical Freudian school. It is written in simple, clear-cut language, and illustrated with excellent clinical material. It deals with the following subjects: the nature of psychoanalysis, free association, the patient-analyst relationship, the patient in analysis, the patient and his family, analytic therapy with children and youth, the analyst's training, choosing an analyst, other forms of psychotherapy, analysis for the middle class, and ending the analysis.

The author uses the definition of psychoanalysis presented in the New International Dictionary as a good, condensed description of the process. Since this is basic to the present review, it will be quoted. "Psychoanalysis is the method developed by Sigmund Freud for analyzing the content and mechanisms of a person's mental life, for purposes of psychotherapy. By dream analysis and similar devices it aids the patient to discover and relive his unconscious memories and to adjust his mental conflicts."

To this definition the author adds that psychoanalysis is carried out by the method of free association. The patient lies on a couch and the analyst sits behind him. The analyst's activity is limited to making nonjudgmental interpretations of the meaning of the patient's associations. The recommended duration for a complete analysis is 800 to 1000 hours, with the sessions as close together as possible, but not less than four times a week. According to the author, any deviation from this technique places the process used in a nonanalytic category, for which the term psychoanalysis should not be used.

Analysis carried out in the manner described above, the author states, will produce beneficial character changes in patients who are amenable to it and who have sufficient ego strength to tolerate the process.

In typical crusading spirit the author indicates, perhaps not intentionally but at least inferentially, that no other form of therapy except psycho-

analysis, as defined and carried out according to the directions set forth in this book, will produce character change in depth. With this view many scientifically and experimentally oriented analysts will disagree, for they feel that the last word in technique will never be said and that psychoanalysis is not a static but an expanding discipline.

The author states that such terms as "group psychoanalysis" are inaccurate descriptions of both group therapy and psychoanalysis. If, however, the author accepts the New International Dictionary definition as accurate, there would seem to be some inconsistency in this conclusion, since in psychoanalysis in groups the patient does in fact analyze the content and mechanisms of his mental life and does relive his unconscious memories and resolve his mental conflicts.

Commonsense about Psychoanalysis fulfills its goal, namely, to answer questions which commonly arise about the classical method of psychoanalysis. Even though some of the statements made about other schools of psychoanalysis cannot be accepted as matters of fact, the book serves a useful function and is well worth reading.

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CURRENT PSYCHIATRIC THERAPIES, VOL. I. Edited by Jules H. Masserman.
New York: Grune & Stratton, 1961, 256 pp., \$7.50.

This is the first volume of a yearly series intended to bring together articles which represent special contributions in psychiatry, as well as annual summaries of current advances in a variety of modes and techniques of therapy.

Volume I has multiple papers—from those on preventive psychiatry through childhood and adolescence, to broader aspects of institutions and community work, as well as aftercare programs. This book appears to be of value in terms of offering a broad sampling of varieties of approaches in treatment of the mentally ill.

Particularly noteworthy are the two articles on psychotherapy and drugs, with an excellent review on psychopharmacology which should serve as a good reference source. Of particular interest to the group psychotherapist are two papers by David Schecter and Walter Bromberg which review current thinking regarding the integration of group therapy with individual psychoanalysis, as well as providing a review regarding current advances in group psychotherapy.

A thoughtful article by Masserman on "Anxiety and the Art of Healing" raises pertinent questions regarding the efficacy of our therapies and on the fact that notations of results are so deeply influenced by the observer's predilections. Masserman discusses anxiety from what he considers

the basic three parameters, i.e., man's concern with and abhorrence of physical injury and death; second, anxieties as to the reliability of human alliances, and, third, man's rejection of a concept of being little more than a cosmic triviality. Defense systems, he feels, are related, accordingly, to attempts to master the material milieu through science and technology, to master social relationships through familial, economic, and political compacts, and, lastly, defensive mastery through philosophic and religious systems. The great task that falls upon the therapist to meet the total needs of the patient are thus put in the light of dealing with these three modalities. Masserman makes a plea for continued search and research, eclectic in approach and not bound by esoteric concepts.

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LECTURES ON EXPERIMENTAL PSYCHIATRY. Edited by *Henry W. Brosin*.
Pittsburgh: University of Pittsburgh Press, 1961, 365 pp., \$7.50.

This volume, which presents 17 papers initially prepared for the 1959 Conference on Experimental Psychiatry at the Western Psychiatric Institute and Clinic, University of Pittsburgh, accepts the assumption that the psychiatrist must understand the whole man in order to cope effectively with "disorders of the psyche." Obviously, no single volume can adequately encompass this unfettered view of psychiatry; yet, this one makes a very creditable effort. The authors of the various papers include some of the undoubted mahatmas in their respective fields, particularly in the areas of clinical psychiatry, neuropharmacology, neuroanatomy, and neurophysiology. It is pleasant to report that for the most part these pundits have lived up to their reputations and have perhaps further enhanced them.

The editor has wisely and humanely omitted any reference to the inevitable "questions and discussions from the floor," which usually burden such compilations. He further spared himself the chore of attempting to organize the papers according to content areas, and, instead, presents the authors alphabetically. Readers may conclude after careful review of the total content that, in fact, such organization could not be improved upon.

Implicit in the concept and purpose of this volume is the recognition that further progress in psychiatry requires expanded knowledge rather than the wider or more earnest application of current psychotherapy practices. It is somewhat disappointing, therefore, to find that most of the clinical psychiatry contributions are neither novel nor experimental. Unfortunately the clinical work stemming from the experimental application of learning theory, such as that represented by Goldiamond, Krasner, Lindley, and Wolpe, are not represented in this volume. As a consequence, there is instead a presentation of fairly orthodox theory. One reads the clinical

reports with the ease and comfort of finding oneself among familiar concepts that unfortunately are like old and respected friends who have grown somewhat feeble with age.

The clinicians have, for the most part, restricted themselves to expatiating on the tried and presumed-to-be-true variables, but fail to present supporting data. It is as if the clinician-therapist has been dealt a handful of concepts by the founders of the field and has decided to play these on the assumption that he holds a pat hand. The constant reshuffling of the cards, which formerly produced exciting combinations, now appears to do so at a diminishing rate.

In contrast to the meager contribution of the clinical psychiatrists are the impressive papers by Elkes, Marrazzi, and Patton in the respective fields of psychotropic drugs, neuropharmacology, and neurophysiology. These papers provide important summaries and integrations of these fields and as such should have lasting reference value.

Perhaps the most remarkable paper of this collection is McCulloch's. In an unself-consciously personal document, he presents a resumé of recent European work in neurophysiology as well as his efforts to bring the insights of cybernetics to it. The report is based on his tour of research organizations in quest of: "Where is fancy bred?/Or in the heart or in the head?/How begot, how nourished?" It includes a fascinating account of how fancy is bred and nurtured in McCulloch and as such is of particular interest to students of creativity.

In keeping with the broad view of the field of psychiatry, Kubie undertakes to discuss the training needs of the psychiatrist. He proposes that the young psychiatrist's training, which he persuasively argues should be government subsidized in its entirety, should include a minimum of five years of half-time analytic training, followed by ten years of half-time analytic practice. "The other half of these fifteen years would be spent in laboratories of experimental psychology, neurophysiology, neurobiochemistry, mathematics, and modern electronic neurophysiology." He further proposes that the age of 45 or 50 be designated as the "... minimum age of consent before which it becomes statutory rape to force anyone to teach psychiatry or do research in psychiatry" (page 222). This will strike many as an extraordinarily exciting proposal in many regards, not the least of which is the implication that journals might be hesitant to publish the works of those under this defined age of maturity. We may speculate that it might become fashionable to assess maturity by judging the ability to resist the impulse to publish.

The participants in the Conference seem to concur in the view that there are probably few bodies of knowledge which the psychiatrist may safely class as irrelevant to his field. The psychiatrist must strive to become the "complete scientist." One cannot fail to be impressed by psychiatry's high level of aspiration. It is well to remember, however, that efforts to incorporate the knowledge of a wide variety of fields does not constitute evi-

dence of the growth of psychiatry as a discipline. This can only be demonstrated by its contributions to other fields, and particularly to its own.

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VIRGIN WIVES. By *Leonard J. Friedman*. Springfield, Ill.: Charles C Thomas, 1962, 149 pp., \$4.50.

This book is a study of 100 cases of unconsummated marriage with a duration of two years or less to more than five years. There are case reports of sixteen patients representing many types of personality patterns. The impressive result of successful treatment in 71 per cent of the cases with combined medical and psychotherapeutic techniques may seem surprising to many readers, except those who, like the reviewer, have worked for many years in a family planning clinic.

The treatment in these cases was individual. Group therapy was used for the doctors who treated the patients. The leader was a psychoanalyst. The purpose was to use these group seminars as supervisory to teach the doctors brief psychotherapy, not only to work out the interaction of emotional and physical factors, but also to demonstrate the emotional interaction between patient and doctor.

Among the many interesting findings in these cases were that childhood traumas did not appear to be an important cause of later nonconsummation and that expression of disgust about intercourse was a poor prognostic sign.

In about 35 cases the husband was impotent to some degree, but it had no significant relationship to the progress. Though the presence of a collusive pattern between the spouses was recognized, treatment of the wife alone was sufficient to lead to consummation in a high proportion of the cases.

The study demonstrates well the advisability of group supervisory sessions for medical personnel in treatment of psychosomatic disorders.

LENA LEVINE, M.D.
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GROUP PSYCHOTHERAPY WITH CHILDREN: THE THEORY AND PRACTICE OF PLAY-THERAPY. By *Haim G. Ginott*. New York: McGraw-Hill, 1961, 208 pp., \$5.95.

This book starts with a discussion of the theoretical framework for group play-therapy. Next it analyzes the selection of children for group play-therapy and the composition of groups. The chapter on differential diagnosis through play observation is brief in terms of content but richly concentrated in clinical observations and helpful insights. The chapters on the rationale for toy selection, on the play and activity room, and the therapy hour contain practical knowledge which should be most helpful for the beginning practitioner. The problem of setting limits in group play-therapy and what to do when limits are broken, although recognized in therapy, often results in confused applications to practical situations. Ginott's chapter on this topic clarifies important basic points which, if followed, will save the group play-therapist unnecessary mistakes and therapeutic errors.

A special chapter is devoted to the qualities and qualifications of the child therapist. The various gratifications a therapist might derive from working with children compare to the beckoning islands of Scylla and Charybdis. Objective maturity and self-understanding, among other characteristics of the child therapist, will prevent therapeutic shipwreck.

The chapter on research in play therapy critically evaluates what has been done in terms of studies in the field of group play-therapy.

The last two chapters are important ones because they deal with the children's parents. Instead of dealing individually with parents in a pre-therapy interview, several of the parents are seen together in a group setting. This enables a clinic to give immediate service, to eliminate non-attenders, to determine emergency cases, and to explain to these parents the nature of the therapeutic services the clinic is equipped to give to their children. The procedure has been found helpful in diminishing anxiety and in lessening resistance among the parents. Seeing the parents of prospective child patients in such a setting can also be very helpful to the staff in the formulation of diagnostic impressions of the children to be treated. The author describes the method of (parent) group guidance which differs from group psychotherapy and group counseling. In group guidance an attempt is made to "improve the functioning of parents in relation to their children. . . . Mothers and fathers are helped to understand the dynamics of parent-child relations and the basic facts of child growth and needs."

The author, in the preface, writes that the concepts in his book are derived from psychoanalytic therapy. This reviewer, however, whose orientation toward child therapy is a psychoanalytic one, looked in vain for an amplification, elucidation, and deepening of the psychoanalytic theory of the child. Ginott's bibliography lists predominantly the contributions of nondirective therapy to play therapy. The examples quoted by the author,

in the manner of reporting and content, resemble very closely those of Axline and Moustakas. The psychoanalytic contributions made to child therapy and play therapy are either very briefly mentioned or totally omitted. Anna Freud is quoted, but no mention is made of Melanie Klein, Margaret Lowenfeld, Eric Erickson, Helen Beiser, Lois Barkley Murphy and many others who have contributed to theory and practice in the ever-growing field of child therapy and play therapy.

Ginott's volume is a practical book. It grew out of years of active working with children. His supervisory experiences and his conducting of workshops in group play-therapy led to the formulation of direct questions for which direct answers had to be found. This accounts for the practical orientation of the book. One might differ with the author about theoretical construction of the book. One might differ with the author about the first constructs, but the fact remains that Ginott has given to the profession the first practical and informative book on group play-therapy. The book is very readable, well organized with appropriate chapter headings, subtitles, and photos. It has all the earmarks of becoming a textbook. This reviewer feels that it will be read and used wherever group play-therapy with children is either taught or practiced.

ADOLF G. WOLTMANN
New York, N.Y.

COTTAGE SIX. By *Howard W. Polsky*. New York: Russell Sage Foundation, 1962, 185 pp., \$3.95.

This book is a penetrating sociological analysis of the group structure and value system of boys in a cottage in a residential treatment institution known as Hollymeade (a disguised name for a rather well-known residential treatment school). The author, who developed his material through serving as a participant observer in a cottage reputed to house the more aggressive boys, highlights in trenchant form a factor that has been on the horizon of awareness of those who are concerned with the treatment of children in placement. Children develop and maintain a culture of their own which has its own values and momentum and does not permit the intrusion of adult values. As is dramatically highlighted in this book, the adults, in order to minimize the state of tension and anxiety between themselves and the child, often join this value system and contribute to the delinquency pattern.

The author dramatically describes his own awareness of his propensities to join the culture of the boys and of the difficulty involved in maintaining one's own integrity and value system. Noteworthy is the fact that when the adult in the institution feels put upon by the administration, the channels of release for feelings that are engendered is often one of joining the boys in their sentiments against the administration. The author appears

to be somewhat pessimistic of the results of individual therapy between caseworker and boy, feeling that often the caseworker brings a middle-class value system that does not relate itself to the more primary codes of the youngster. Recognizing the difficulty of individual therapy with character disorders, one needs to raise the question of the possibility of group treatment. S. R. Slavson has clearly demonstrated in his experimental projects the feasibility of group psychotherapy in the institutional setting.

This book serves as an antidote to the complacent feelings that often develop when the community has "successfully placed a child" in a treatment institution. The drama in this book is the inexorable force of delinquent values and their corrupting influence on those who are responsible for therapy. "Hollymeade," in allowing this valuable piece of research, has exhibited a courage that hopefully will result in more intensive focusing on our efforts in the field of residential treatment.

In reading the book many questions are raised. Primary is the question as to whether the system of cottage parents needs to be thoroughly studied and revised. Also, what forms of communication need to be developed and maintained so that all adults responsible for working with the child and the group are able to maintain a consistent approach that does not allow for manipulation. What are the effects when the adult in the child's environment does not hold out hope and encouragement for change? The individual and the group become reinforced in their delinquent value systems as a means of coping with the world that is frightening. The dramatic revelations of this study need to be tempered by the recognition and acceptance that there is an inevitable boundary line between all children and adults. It is the adult who must create the atmosphere for the child's willingness to cross the line. As the author indicates, when the adult descends to the level of the child, barricades are quickly erected.

This book hopefully will serve as a stimulus to research and self-examination. A preface by the Director of "Hollymeade" indicates that this process is already underway.

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CRIMINAL PSYCHOLOGY. By *Richard W. Nice*. New York: Philosophical Library, 1962, 284 pp., \$5.75.

This volume is made up of ten chapters which have been composed by nine different authors. Each chapter stands as an individual topic, and there is an individual bibliography and set of notes for each chapter. There is no over-all treatment of the material covered. The book serves largely as an opportunity for the authors to collect and publish on topics pertaining

to "forensic medicine in the psychiatry area." The topics covered are as follows: (1) the psychiatrist's role in the administration of criminal justice, (2) insanity as the defense for a criminal act, (3) the psychologist in today's legal world, (4) the psychiatric approach to crime and correction, (5) justice as a psychological problem, (6) the definition of mental illness, (7) treatment for criminals, (8) treatment of offenders: the family influence, and (9) the future of court psychiatry.

At the crossroads of law, the court, and the role of the physician as an expert witness are out-dated traditions, confusions in thinking, and ethical and metaphysical problems. The scientific reader of this volume will be overwhelmed by how far the traditions of forensic psychiatry must go in order to reach the simple, well-established scientific principles of the present day. The book is a revelation of the degree to which medieval considerations of law in psychiatry still face the modern court. The mind-body problem, the problem of free will, the question of diagnosis, the problems of defining mental illness are all manifest in their most unresolvable forms in this volume.

To the reviewer, the most interesting chapters in the book are those by Meerloo, "Justice as a Psychological Problem," which organizes attitudes to the idea of justice in a relatively interesting and creative way; and the chapter by Weihofen, "The Definition of Mental Illness" written by a Professor of Law and facing rather directly the problems of the antiquated legal structure.

Each of the chapters is replete with bibliographic material, and the number of references would certainly be useful to the student; yet, beyond this, it is difficult to place the group for which this volume has been written, for the naive student would need considerably more guidance in clear thinking than the volume offers and the more sophisticated student might feel it more worth his while to go to real authorities in the field of forensic psychiatry for reference material.

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PROCEDURES FOR IDENTIFYING PERSONS WITH POTENTIAL FOR PUBLIC SCHOOL ADMINISTRATIVE POSITIONS. By *William C. Schutz*. Berkeley: Berkeley University of California Press, 1961, 194 pp. (paperbound).

This study is a well thought out and carefully designed effort to establish objective measurements for the selection of school administrators. The authors appear to be cognizant of the hazards in their undertaking and of the need to apply the testing procedures to greater numbers. The temptation to reduce the factors in human relations to statistical analysis is a great

one. Much, however, can be lost in such a process, for interpersonal relationships involve so very many different aspects, feelings, attitudes, experiences. Have the authors considered the possibility of longitudinal or life history studies of large numbers of school administrators? Such studies might very well parallel or supplement their current efforts.

Criteria for teacher selection have long been a concern of educators. Efforts to develop measurement scales have been made. To date, no completely validated methods for such selection have been available. Have the authors considered this work? Might not their efforts have been directed toward this problem first? We raise this point since the selection of school administrator is usually made from the teacher ranks. If we can develop valid measurements here, this would greatly expedite the development of objective ways to select school administrators.

We were impressed with the strong orientation of the authors toward psychiatric theories of dynamically motivated behavior. This is good and leads us to believe that the authors are very much aware of all the possible implications in the field of their study. Any critical comments that we have relate primarily to details. At the outset the authors state that "accomplishing goals of the group is more important than the specific behavior used to reach the goals" (p. 16). We take issue with such a statement because we believe on ethical grounds that the means is important, that they can be highly destructive.

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A.G.P.A. NEWS

Edited by CHARLES G. McCORMICK, Ed.D.

Recently elected members of the A.G.P.A. Board of Directors are: Joseph J. Geller, M.D., Samuel B. Hadden, M.D., Jean Munzer, M.D., Ph.D., Howard P. Rome, M.D., and Bertram Schaffner, M.D. They will serve for three years. The following members retired from the Board this year: Irving L. Berger, M.D., Arthur Eaton, M.S.W., Beryce W. MacLennan, Ph.D., Irving Schulman, Ph.D., and Lewis R. Wolberg, M.D.

EASTERN SOCIETY

Reports from the chairman of the Society's Education Committee and the *Newsletter* edited by Max Rosenbaum, Ph.D., indicate the election of a new president, workshops conducted last fall and this past spring, and a special award meeting, held in conjunction with the annual business meeting, at which Alexander Wolf, M.D., was honored for his work in the field of psychoanalysis in groups. This last named event took place at the Academy of Sciences in New York City. Dr. Wolf spoke on "Reminiscences and Prospects of Group Psychotherapy."

Frederick Rath, M.D., of Woodmere, New York, is the incoming president. He succeeds Asya Kadis in this office.

Ruth C. Cohn announced four workshops in group psychotherapy for the spring of 1963: Research Methods in Group Psychotherapy; Methods and Techniques of Child Group Therapy; Group Therapy and Adolescents; and Supervisory Techniques in Group Therapy. The instructors chosen for these workshops were Charles Winick, Ph.D., Adolph G. Waltman, Betty Gabriel, S. R. Slavson, and Hyman Spotnitz, M.D.

There were two workshops in the fall of 1962, Theory and Application of Group Psychotherapy, with Jack Krasner, Ph.D., Jean Munzer, M.D., and Arlene Wolberg, Ph.D., instructors in the first, Asya Kadis and Helene Papanek, M.D., instructors in the second.

GOLDEN GATE SOCIETY

Plans to entertain the Annual Conference and Institute of the American Group Psychotherapy Association in 1965 are already outlined. The meetings will be held in San Francisco. Franklin H. Ernst, M.D., announced A.G.P.A.'s acceptance of the invitation from the Golden Gate Group Psychotherapy Society.

Information regarding tours and points of interest can be obtained by writing the San Francisco Convention and Visitors Bureau, 1375 Market Street, San Francisco.

LOS ANGELES SOCIETY

The chairman of the Publicity Committee, Katherine Kaplan, A.C.S.W., announced that the Los Angeles Group Psychotherapy Society held its fourth Annual Meeting on March 16th at the Statler Hotel. The principal address was given by John E. Bell, Ed.D., whose subject was "The Family Group Therapist—An Agent of Change." Dr. Bell is Program Director, National Institute of Mental Health, Region 9, Public Health Service. His paper was discussed by Saul Brown, M.D., Director, Department of Child Psychiatry, Mt. Sinai Hospital in Los Angeles.

In addition to this address there were ten workshops in the morning and in the afternoon. The subjects of these workshops were as follows:

1. Technical Principles of Group Psychotherapy;
2. Family Therapy;
3. Group Therapy with Married Couples;
4. Individual and Group Therapy—Indications, Combinations and Contrasts;
5. Problems of Transference and Countertransference;
6. Group Therapy with Psychotic and Borderline Individuals;
7. Group Therapy with Alcoholics;
8. Group Therapy with Adolescents;
9. Group Therapy with College-Age Youths;
10. Group Therapy with Children.

John S. Peck, M.D., was chairman of the Program Committee and Jeanette Targow, M.S.W., chairman of the Arrangements Committee.

LOUISIANA SOCIETY

"The Role of the Leader in a Psychotherapy Group" was the theme of the Second Annual Institute of the Louisiana Group Psychotherapy Society, held Friday, April 5th and 6th, at the Turo Infirmary, New Orleans. The visiting lecturer and senior workshop leader was Milton M. Berger, M.D., of New York City.

In all, there were ten workshop leaders. These were: Milton M. Berger, M.D., James H. Brown, M.D., Arthur P. Burdon, M.D., George J. Caruso, M.D., Clayton B. Edisen, M.D., Charles A. Feigley, M.D., Donald D. Lamthrop, M.D., Arthur S. Samuels, M.D., Vann Spruiell, M.D., and Max Sugar, M.D.

MAINE SOCIETY

A joint meeting of the Maine Group Psychotherapy Society, the Portland Committee on Alcoholism, and the Southern Maine Mental Health Association, held on Saturday, April 27th, at Boys Training Center in South Portland, provided the membership and guests with three lectures and five workshops on various problems in the fields of psychiatry and psychotherapy, all bearing on the pathological use of alcohol.

Two papers presented in the morning, one by Gilmore Soule, M.D., and another by Oron Kirkby, dealt with "Group Psychotherapy in Relation to Alcoholism" and "Preservation of the Family Unit." The luncheon lecture by Ebbe Hoff, Ph.D., M.D., was "A Comprehensive Approach to the Treatment and Rehabilitation of the Alcoholic and His Family."

The titles of workshops conducted during this day-long conference were as follows: Rehabilitation; Formation of Clinic Facilities; Therapy of Alcoholics; Group Therapy; Therapeutic Experience. The leaders were Ebbe Hoff, Ph.D., M.D., Reuben Leitman, M.D., William Schumacher, M.D., Edward McGeachey, M.S.W., Harold Libby, M.D., Stanley Sylvester, M.D., Oron Kirkby, Nicholas Fish, M.D., Gilmore Soule, M.D., Arthur Freundlich, M.A., Eli Forsley, Ed.D., and Calvin Jordan, M.Ed.

MID-ATLANTIC SOCIETY

The Mid-Atlantic Group Psychotherapy Society is welcomed as the eleventh Affiliate Society of A.G.P.A.

Eduard Ascher, M.D., president of the Mid-Atlantic Group Psychotherapy Society described a special provision for participation by nonmembers in the activities of the Society; the Constitution establishes "Provisional Members" which permits candidates who have not as yet qualified for membership in A.G.P.A. to join the Society as nonvoting members. A time limit of one year is placed on such memberships.

SOUTHWESTERN SOCIETY

A unique Retreat and Annual Meeting limited to fifteen registrants, held at the Houston Yacht Club in LaPorte, presented Asya L. Kadis of New York City as leader of an intensive series of seminars on group psychotherapy. Irvin A. Kraft, M.D., president of the Southwestern Society, announced that the Retreat took place Thursday afternoon, April 25th, through Sunday afternoon, April 28th. A yacht trip on Friday evening was one of the features of the meeting.

SOCIETIES IN FORMATION

Albert W. Silver, Ph.D., president of the Michigan Group Psychotherapy Society, reported that a "week-end training laboratory" was held from Friday through Sunday, February 22nd to 24th. The leaders for the conference were a sociologist, Ronald Lippitt, Ph.D., a psychologist, Daniel Miller, Ph.D., and a human relations expert, Kenneth Benne, Ph.D.

The chairman of the Committee on Local and Regional Affiliate Societies of the American Group Psychotherapy Association, Helene Papanek, M.D., has announced that in addition to the Michigan Society there are three Societies working toward affiliation. They are located in Illinois, Minnesota, and Georgia.

In addition, Dr. Papanek has provided some statistics obtained from five Local Societies represented at the Annual Conference of A.G.P.A. on January 24th of this year. As of that date membership totals were as follows: Eastern Society, 220; Louisiana Society, 20; Maine Society, 15; Mid-Atlantic Society, 32; Tri-State Society, 32.

NORMAL PSYCHOLOGY OF THE AGING PROCESS

Edited by

NORMAN E. ZINBERG and IRVING KAUFMAN

\$4.50

There are approximately fifteen million people over the age of sixty-five in the United States; it is expected that in ten years there will be five times as many. To date, professional interest has been limited largely to concern with external factors which impinge on the aged. Intrapsychic factors have received little attention.

The Boston Society for Gerontologic Psychiatry has chosen to study the psychological make-up of the aged in whatever ways it may differ from the younger age groups, with the focus of interest on "those variables which determine successful or adaptive old age versus unsuccessful, or psychological failure in old age." This volume represents its first and very worthy effort in that direction.

The contributors discuss the fundamental theoretical and clinical aspects of *normal* aging in the belief that "we must delineate ontogeny before attempting to determine deviation." They consider the relationship of the physiology to the psychology of aging. They regard aging from their common psychoanalytic frame of reference and examine the changes in id, ego, and superego, vicissitudes of the sexual and aggressive instincts, and interpersonal relationships. Aging is also viewed in terms of social and cultural implications. The psychopathology of the aging is briefly sketched in, chiefly from the point of view of special difficulties of adjustment which mental illness creates for the geriatric patient in the community.

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A SYMPOSIUM ON THE RELATIONSHIP OF GROUP PSYCHOTHERAPY TO GROUP DYNAMICS¹

INTRODUCTION

LEWIS H. LOESER, M.D., and MORRIS B. PARLOFF, Ph.D.

The purpose of this symposium was to bring together group therapists and social scientists who are students of small groups in the hope that each might more fully understand and utilize the observations, research, and insights of the other. To accomplish this, two panels were organized: one to represent social science researchers and theoreticians concerned with small groups, the other to represent practitioners concerned with the conduct of group psychotherapy. One member of each panel was selected to present a paper, and the remaining three members acted as discussants of the paper presented by the other panel. Requirements for membership on these panels were eminence in the field of primary identification plus familiarity with the field represented by the second panel.

The co-chairmen of this symposium felt that previous conferences which self-consciously set about to "bridge the gap" between theory and practice by the device of confronting one discipline with the findings of the other had fallen short of the mark. Some of the bases for this failure are touched upon in Parloff's paper, "Group Dynamics and Group Psychotherapy: A State of the Union." In brief, the central problem is that such parochial presentations leave to the auditor or reader the extremely difficult task of correctly translating the concepts and findings of a relatively alien field into his own more congenial terms and frames of reference. Under these conditions it is likely that the relevance of unfamiliar observations to one's own field of interest may be overlooked.

Our goal was to select panelists whose familiarity with each other's fields would enable them to provide the necessary bridging and integration of both areas. It was further required that the papers presented by the two panels be directly relevant to the primary task of the other; that is, the paper of the social scientist had to be directly related to the practice of group therapy and the paper of the group therapist directly related to the dynamics of small groups. Drs. Herbert Kelman and Elvin Semrad were selected as eminently qualified to undertake these assignments for the group dynamics and group therapy panels respectively. The group dynamics panelists

¹ This symposium was held at the Twentieth Annual Conference of the American Group Psychotherapy Association, January, 1963.

whose task it was to discuss the paper of Semrad et al., consisted of Warren G. Bennis, Ph.D., Professor of Psychology, School of Industrial Management, Yale University; Hubert Coffey, Ph.D., Associate Professor of Psychology, University of California, Berkeley; and Theodore Mills, Ph.D., Associate Professor of Sociology, Yale University.

The panelists of the group psychotherapy paper who discussed Dr. Kelman's paper include: Jerome D. Frank, M.D., Professor of Psychiatry, The Johns Hopkins University School of Medicine; Harris B. Peck, M.D., Associate Professor of Psychiatry, Albert Einstein College of Medicine; and Saul Scheidlinger, Ph.D., Group Therapy Consultant, Community Service Society, New York.

A general introduction to the issues which provided the stimulus for this symposium is presented in the paper: "Group Dynamics and Group Psychotherapy: The State of the Union." This is followed by "The Role of the Group in the Induction of Therapeutic Change" by Dr. Herbert Kelman. The final paper of this symposium is "The Field of Group Psychotherapy" by Elvin V. Semrad, Stanley Kanter, David Shapiro, and John Arsenian.

To implement the goal of the symposium, the principal speakers of each panel were asked to avoid presenting a formal review of either group dynamics research or the current practice of group psychotherapy. Instead, it was suggested that they present analyses of the dynamics and processes of psychotherapy groups from the vantage point of the social scientist and of the group therapist. Such reports were to reflect, however, a thorough knowledge and integration of the relevant group dynamics and group psychotherapy literature.

These then represented the aims, organization, and guidelines of this symposium.

GROUP DYNAMICS AND GROUP PSYCHOTHERAPY: THE STATE OF THE UNION

MORRIS B. PARLOFF, Ph.D.¹

The investigations of groups by social scientists and by group therapists have been conducted and have flourished in the absence of any notable close liaison between these disciplines. Each field appears to thrive in untrammelled isolation from the other. If we accept the assumption, however, that the aim of students of group processes is the development of a science regarding the nature of groups and that the aim of group therapists is the therapeutically effective application of such knowledge, then it is obvious that each field has much to offer the other.

Granting that an undesirable hiatus exists between the student of small groups and the group therapist, it is not probable that this gap exists merely as a consequence of each group's having inadvertently overlooked the work of the other and that it will quickly disappear in the universal solvent of communication. It is my purpose, then, to begin this symposium by acknowledging some of the forces that appear to be operative in maintaining this division.

The differences between group dynamics and group therapy stem basically from the fact that each emphasizes different *aims*, utilizes different *methods*, and selects different *variables* for intensive study. To complicate the situation further there is a split among group therapists regarding the therapeutic role to be assigned to "group phenomena." In order to underscore the issues, I intend to risk exaggerating the actual situation by postulating a dichotomy among group therapists. I shall describe one school as "Individual-Oriented," in that it is concerned primarily with the members who comprise the groups, and the other as "Group-Oriented," for it deals primarily with the group as a unit.

I shall amplify this distinction later, but first let us consider the problems posed by the fact that group dynamics and group therapy stem from different basic assumptions and different *aims*. The investigator who has chosen groups as a field of study views the formulation of laws of group development and functioning as an end in itself. The group therapist, on the other hand, is concerned with effecting therapeutic change in individuals who are being treated in a group setting. The group dynamics student views himself as a scientist and theoretician; the group therapist sees himself primarily as a clinician who artfully utilizes his knowledge of

¹ Chief, Section on Personality, Laboratory of Psychology, National Institute of Mental Health, Bethesda, Maryland.

the dynamics of the individual—and of the group—to enhance the functioning of his patients.

To achieve these different aims the group researcher tends to use the methods of experimental science, while the group therapist tends to rely on naturalistic observation. The social scientist strives for methodological rigor by formulating hypotheses, controlling appropriate variables, and manipulating relevant conditions. Such an investigator makes limited use of therapy groups as objects of study, in part, because the therapist is loath to condone the experimental manipulation of therapy groups.

The observations of group therapists have led to anecdotal reports and clinical descriptions of group processes. The writings of group therapists have provided provocative hypotheses and speculations which all too rarely have been put to an adequate test either by the group therapist or by the group dynamics researcher.

The experience of group therapists and group dynamicists appears to come from quite different types of groups. The group researcher typically deals with groups composed of individuals who meet together for some clearly specified purpose which is to be achieved by a predetermined time. The task is usually of extrinsic interest to the group members and, unlike the task in therapy groups, generally does not center on members' personal problems. The nature of the face-to-face interaction is restricted. Such groups may permit the study of the effect of the group upon the individual, but from the point of view of the group therapist, they do not provide the opportunity to study the effect of group life on the personality. Personality variables are either not considered or are experimentally controlled.

The group therapist experiences disappointment with group dynamics findings based on short-term groups for he is primarily concerned with the development of relationships among group members over prolonged periods. A further criticism is that the experimenter, particularly in problem-solving rather than in training groups, does not appear to pay sufficient attention to the relationship between the group subjects and himself. The psychotherapist postulates that a prerequisite condition for effecting change in patients is that they experience intense emotions. The nontherapy, non-training groups do not require or promote such emotional involvement.

Before turning to the problem of the *variables* which therapists and social scientists select for study, it is necessary to develop further the reference made previously to the two schools of group therapists: one characterized as Individual-Oriented and the other as Group-Oriented. Members of these two schools react quite differently to the specific variables with which the group dynamicist is concerned. The Individual-Oriented group therapist rejects many of the variables described by students of small groups as being either irrelevant to group therapy or actually dangerous to

group therapy and therefore to be avoided. The Group-Oriented therapists, however, find these concepts can be adapted to their own theory and practice of psychotherapy. In order to understand the views of these two factions, it is necessary to review the premises on which they base their work. The Individual-Oriented group therapist postulates that group therapy does not involve significantly more than the techniques, goals, and theory of individual psychotherapy. He deals with individual psychodynamics and the influence of the behavior of the members and the therapists on each other. The group is viewed merely as the setting in which these events occur. Some therapists of this persuasion believe that the psychological laws which apply to the individual apply equally well to the group. The basic Freudian concepts of genetic psychology, psychodynamics, and pathology are believed to be directly applicable to the group. The therapist who is trained in individual therapy will not, according to this position, gain new insights regarding psychotherapy from conceptions specific to group phenomena. Group dynamics research, it is argued, deals only with the conscious productions of group members and therefore overlooks the more powerful issues inherent in the unconscious.

From this point of view, all phenomena which are useful for group therapy, such as the development and analysis of transference, intensification of emotions, stimulation, contagion, countertransference, etc., are to be construed not as group dynamics but rather as interpersonal interaction.

The extreme position of the Individual-Oriented group therapist is that such phenomena as common group goals, cohesiveness, leadership, etc., are antagonistic to effective group therapy and are therefore to be avoided (Slavson, 1957). A somewhat less vehement but perhaps equally scornful attitude is betrayed by therapists who, although acknowledging that some group phenomena may be conducive to therapeutic change, argue that the group therapist need not concern himself with them since such group processes may be classed as "natural" and will therefore function regardless of whether the therapist is aware of them or not. These therapists state that group forces will help propel the group toward its goals automatically, and even in the event that such group forces should tend in the opposite direction, there is no need for concern since the therapeutic process will effectively counteract them (Durkin, 1957). This optimistic position holds out the comforting thought that what the group therapist doesn't know about group dynamics won't hurt him or his patients.

The second, and by far the smaller, school of group therapy focuses on the group as a unit and is therefore in principle more accessible to the influence of group dynamics research. In a sense these therapists have developed a philosophy which effectively reduces the therapy group to the status of a single unit, that is, a single individual. Bion (1959), for

example, attempts to deal with total group aspects of an interaction, i.e., the group culture. He attempts to uncover the basic assumptions or mechanisms underlying the establishment of a common group culture. Ezriel (1950) reports that group members share common group tensions. Independent of the content being discussed by group members, the group is always dealing with an underlying common group tension of which it is unaware but which determines its behavior. These therapists assume that focal conflicts characterize the group rather than any single patient. As a consequence, the therapist is to attend to the statements of the group members as if they were free associations relevant to a basic assumption or focal conflict shared by all group members. It is further assumed that all of the elements of the interaction are relevant to the shared preconscious group focal conflict. These group therapists, unlike the Individual-Oriented group therapist, believe that the work of such investigators as Stock and Lieberman (1962) and Schutz (1958) deals with the unconscious in a meaningful way.

The term group dynamics appears to conjure up different images in the minds of group dynamicists and group therapists. This is due in part to the fact that there is no agreed-upon definition of the term group dynamics. According to Cartwright and Zander (1953), "The most troublesome obstacle to the establishment of a generally acceptable theory of group dynamics lies in the great disagreement that now exists concerning the basic variables, concepts, or facts with which the [group dynamics] laws will deal." Additional confusion stems from the fact that the therapist interprets the term dynamics to refer to such phenomena as emotions, drives, conflicts, defenses, etc. To the group researcher, however, the term refers to such group properties as goals, norms, social interaction, roles, cohesiveness, leadership, and the like. The term group dynamics appears to have attained greatest clarity in the minds of those therapists who interpret it as synonymous with those concepts they choose to reject. This may explain why one eminent therapist has concluded that the development of group dynamics must be "nipped in the bud" if psychotherapy groups are to be effective (Slavson, 1957).

Despite the fact that the student of small groups has not set forth a uniform set of variables which are presumed to be exhaustive, nor even the most critical, for the development and functioning of small groups, there are certain terms and concepts which are quite common to the literature: goals, norms, leadership, conformity, cohesiveness, etc. The Group-Oriented therapist has less difficulty than the Individual-Oriented therapist in recognizing their possible utility for him.

One of the fundamental difficulties appears to lie in the implicit restrictions placed on the interpretation of relevance. Many therapists who

view the so-called group dynamics variables with restrained enthusiasm interpret the question of relevance of such concepts for group therapy in a seemingly rigid and overly concrete manner. If the concept is based on groups which have goals and structure different from therapy groups, then presumably they are *ipso facto* not relevant to therapy groups. There is a tendency to accept or reject a concept on an all-or-none basis. Relevance is more usefully treated as a matter of degree rather than as binary yes or no decision. The researcher seeks to determine the influences which affect the role and significance of given variables in specified situations. He is concerned with being able to specify the manner in which variables are interrelated. He attempts to determine the extent to which specified factors are represented in a given setting. One of the tests of adequacy of the derived hypotheses and laws is their ability to predict behavior in new situations. Such new situations may include groups in which the variables are present in different combinations and in different degrees from the original groups. The investigator must be alert to the fact that additional variables may be needed to account for new group phenomena. The hypotheses are then revised. The fact that therapy groups differ in many ways from the training group or the problem-solving group on which the findings of group dynamics are based is not the crucial issue. The ultimate question is whether hypotheses regarding the interrelationships among variables in one set of groups are supported in different groups such as therapy groups.

How well the aims of group dynamicists to define general laws have been achieved remains an open question. Group dynamics laws which apply only to groups other than therapy groups are obviously of limited value. The student of small groups who is seriously concerned with the formulation of general principles regarding the dynamics of *all* groups must be particularly interested in the observations and experiences of group therapists.

The group therapist must recognize that although groups' motivational forces and processes provide a potential for change and growth, such changes are not an inevitable, automatic, or inherent condition of groups. Group processes are neither inherently therapeutic nor psychotoxic. The constructive utilization of groups presupposes a knowledge on the part of the therapist of the processes which he wishes to encourage and those which he wishes to discourage. It further presupposes that the therapist understands the techniques by which such goals may be achieved. The fact that the student of group processes may focus on some group interactions which the therapist may not value does not warrant their rejection.

As a consequence of the above differences in aim, method, and interest variables, social scientists (group dynamics experts) and group therapists have had a difficult time communicating with one another. The reports of

each group tend to be published in different journals and each group attends different professional meetings. There is a striking paucity of cross-referencing between the disciplines, although both fields have produced extensive literature, with close to 200 books and articles being written in each field every year. It is possible, of course, that the very volume of literature, instead of facilitating communication between fields, may act as an effective barrier. The prospect, to members of each field, of having to read the literature of the other is probably sufficiently monstrous to prompt their cavalier dismissal of that literature as irrelevant.

Having begun this symposium by stressing the state of the disunion, I am in hopes that what follows will include considerations which may help effect a more perfect union.

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THE ROLE OF THE GROUP IN THE INDUCTION OF THERAPEUTIC CHANGE¹

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Psychotherapy can be regarded as a social influence situation in which the patient's relationship to the therapist is the primary vehicle for the production of therapeutic change. In individual psychotherapy, the situation is so arranged as to maximize the probability that the patient's interactions with the therapist will facilitate desirable changes in his attitudes, values, and action-tendencies. In group psychotherapy, the patient's relationships to his fellow-patients and to the group as a whole become additional vehicles for the production of therapeutic change. In choosing between group and individual therapy, one has to keep in mind, of course, that while the patient-group relationship may serve to strengthen forces toward change, it may also bring certain counterforces into play, thus reducing the potentiality for change contained in the dyadic relationship. Whether or not group therapy seems to be indicated, given these competing forces, will depend on the characteristics of the patient, the nature of his problems, and the current status of his general treatment program. Group therapy will be resorted to when there is reason to believe that the combination of therapist and group will make for a more effective influence situation and facilitate the occurrence of the particular changes that are desired.

My use of the term "social influence" does not carry any value connotations whatsoever. It will become clear, as I proceed, that I use the term very broadly to refer to any change in a person's behavior that is induced by another individual or a group. The induction may take many forms: for example, the influencing agent may exert pressure, offer suggestions, attempt persuasion, serve as a model, or make available new information; all of these would be subsumed under the term "social influence," without ignoring, of course, the importance of the qualitative differences between

¹ This paper is a product of a research program on social influence and behavior change supported by Public Health Service Research Grant MH-07280 from the National Institute of Mental Health. In writing this paper, I benefited greatly from my association with Jerome Frank, who taught me about group therapy and whose pervasive influence will be apparent throughout; with Morris Parloff, with whom I collaborated in therapy research and who encouraged me to apply my theoretical notions to the therapy situation; and with Donald Boomer, who supervised me in therapy and shared many of his insights with me. I was also greatly stimulated by the students at Harvard University who participated in my seminars on "Theory and Research on the Therapeutic Relationship."

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them. In describing psychotherapy as a social influence situation, then, my purpose is not at all to expose it as a manipulative process. Rather, it is my purpose to make it accessible to a social-psychological analysis of influence processes, based on theoretical and empirical exploration of a variety of laboratory and field situations. While psychotherapy constitutes a very unique kind of interaction situation, it is nevertheless continuous with other social situations in which changes in behavior and personality are induced. An application to this situation of some of the concepts that have been developed in the study of other influence situations may, therefore, provide a different perspective for viewing psychotherapy and perhaps offer some new insights.

A FRAMEWORK FOR THE ANALYSIS OF SOCIAL INFLUENCE

Specifically, I would like to apply to the therapy situation a theoretical framework for the analysis of social influence with which I have been working over the last few years (Kelman, 1961). This framework has generated a number of specific hypotheses that have been tested experimentally (e.g., Kelman, 1958); and it has also been used in the interpretation of attitude changes found in an intensive field situation (Bailyn and Kelman, 1962). The starting point of this framework is a distinction between three processes whereby influence can be accepted: compliance, identification, and internalization.

Compliance can be said to occur when an individual accepts influence from another person or from a group in order to attain a favorable reaction from the other, that is, to gain a specific reward or avoid a specific punishment controlled by the other, or to gain approval or avoid disapproval from him. Identification can be said to occur when an individual accepts influence from another person or a group in order to establish or maintain a satisfying self-defining relationship to the other. In contrast to compliance, identification is not primarily concerned with producing a particular effect in the other. Rather, accepting influence through identification is a way of establishing or maintaining a desired relationship to the other, as well as the self-definition that is anchored in this relationship. By accepting influence, the person is able to see himself as similar to the other (as in classical identification) or to see himself as enacting a role reciprocal to that of the other. Finally, internalization can be said to occur when an individual accepts influence in order to maintain the congruence of his actions and beliefs with his value system. Here it is the content of the induced behavior and its relation to the person's value system that are intrinsically satisfying.

Each of these three processes is characterized by a distinct set of antecedent conditions and a distinct set of consequents. These are sum-

marized in Table 1. Very briefly, on the antecedent side, it is proposed that three qualitative aspects of the influence situation will determine which process is likely to result: (1) the basis for the importance of the induction, i.e., the nature of the predominant motivational orientation that

TABLE 1*

Summary of the Distinctions Between the Three Processes

	<i>Compliance</i>	<i>Identification</i>	<i>Internalization</i>
Antecedents:			
1. Basis for the importance of the induction	Concern with social effect of behavior	Concern with social anchorage of behavior	Concern with value congruence of behavior
2. Source of power of the influencing agent	Means control	Attractiveness	Credibility
3. Manner of achieving prepotency of the induced response	Limitation of choice behavior	Delineation of role requirements	Reorganization of means-ends framework
Consequents:			
1. Conditions of performance of induced response	Surveillance by influencing agent	Salience of relationship to agent	Relevance of values to issue
2. Conditions of change and extinction of induced response	Changed perception of conditions for social rewards	Changed perception of conditions for satisfying self-defining relationships	Changed perception of conditions for value maximization
3. Type of behavior system in which induced response is embedded	External demands of a specific setting	Expectations defining a specific role	Person's value system

* Reprinted, by permission of the publisher (Kelman, 1961, p. 67).

is activated in the influence situation; (2) the source of power of the influencing agent, i.e., the particular characteristics that enable him to affect the person's goal achievement; and (3) the manner of achieving prepotency of the induced response, i.e., the particular induction techniques that are used (deliberately or otherwise) to make the desired behavior stand out in preference to other alternatives. Thus, compliance is likely to result if the individual's primary concern in the influence situation is with the social effect of his behavior; if the influencing agent's power is based largely on his means-control (i.e., his ability to supply or withhold material or psychological resources on which the person's goal achievement depends); and

if the induction techniques are designed to limit the individual's choice behavior. Identification is likely to result if the individual is primarily concerned, in this situation, with the social anchorage of his behavior; if the influencing agent's power is based largely on his attractiveness (i.e., his possession of qualities that make a continued relationship to him particularly desirable); and if the induction techniques serve to delineate the requirements of the role relationship in which the person's self-definition is anchored (for example, if they delineate the expectations of a relevant reference group). Internalization is likely to result if the individual's primary concern in the influence situation is with the value congruence of his behavior; if the influencing agent's power is based largely on his credibility (i.e., his expertness and trustworthiness); and if the induction techniques are designed to reorganize the person's means-ends framework, his conception of the paths toward maximization of his values.

On the consequent side, the framework proposes that the changes produced by each of the three processes tend to be of a different nature. The crucial difference in nature of change between the three processes is in the conditions under which the newly acquired behavior is likely to manifest itself. Behavior accepted through compliance will tend to manifest itself only under conditions of surveillance by the influencing agent, i.e., only when the person's behavior is observable (directly or indirectly) by the agent. The manifestation of identification-based behavior does not depend on observability by the influencing agent, but it does depend on the salience of the person's relationship to the agent. That is, the behavior is likely to manifest itself only in situations that are in some way or other associated with the individual or group from whom the behavior was originally adopted. Thus, whether or not the behavior is manifested will depend on the role that the individual takes at any given moment in time. While surveillance is irrelevant, identification-based behavior is designed to meet the other's expectations for the person's own role performance. The behavior, therefore, remains tied to the external source and dependent upon social support. It is not integrated with the individual's value system, but rather tends to be isolated from the rest of his values, to remain encapsulated. In contrast, behavior accepted through internalization depends neither on surveillance nor on salience but tends to manifest itself whenever the values on which it is based are relevant to the issue at hand. Behavior adopted through internalization is in some way, rational or otherwise, integrated with the individual's existing values. It becomes part of a personal system, as distinguished from a system of social-role expectations. It becomes independent of the original source and, because of the resulting interplay with other parts of the person's value system, it tends to be more idiosyncratic, more flexible, and more complex. This does not imply com-

plete consistency, nor does it mean that the behavior will occur every time it is relevant to the situation. Internalized responses will, however, at least come into play whenever their content is relevant and will contribute to the final behavioral outcome, along with competing value considerations and situational demands.

I hope that this brief review is sufficient to give the flavor of the three processes of influence. Clearly, the ultimate aim of therapy, at least of insight therapy, is the development of new attitudes, new self-images, and new patterns of interpersonal relationships at the level of internalization. However, as I shall attempt to show, all three processes are typically involved in the therapeutic interaction, and all three are necessary to the production of therapeutic change. Even when internalized change takes place at the conclusion of therapy, compliance and identification serve as ancillary processes: changes at these other levels represent preliminary steps that make internalization possible. Sometimes, as shall be discussed below, changes produced in therapy may not proceed to internalization but remain fixated at the level of compliance and identification.

CHANGES WITHIN AND OUTSIDE OF THE THERAPY SITUATION

Before spelling out the way in which the three processes enter into the production of therapeutic change, I would like to make a further distinction between two phases of behavior change to which the therapeutic relationship must address itself. Very simply, these are changes in the patient's behavior *within* the therapy situation and changes in the patient's behavior *outside* of the therapy situation (cf. Kelman, 1952).

First, the therapist and the group have to exert influence on the patient's behavior within the therapy situation in order to be certain that the patient will engage in the therapeutic process and thus open himself up to the therapeutic potential of the situation. The model of the therapy situation that I have in mind here is that of a situation so set up that the patient is both freed and forced to overcome his resistances and to think and talk about things he ordinarily avoids; the greater freedom allows him to *experience* certain feelings in the therapy situation and to express these feelings as he experiences them; as he engages in this process, corrective emotional experiences in the therapy situation become possible, i.e., experiences marked by the simultaneous occurrence of intense feelings and the examination of these feelings. To make the occurrence of this process possible and likely, the therapist and the group must influence the patient to shed his resistances, to allow himself to experience certain threatening feelings, to express these feelings as he experiences them, and to examine them as he expresses them. In short, they must induce changes in the

patient's behavior within the therapy situation so that he will increasingly meet the requirements of the therapeutic process.

But, obviously, changes in the patient's behavior within the therapy situation are not enough. To be effective, therapy must produce changes in the patient's behavior outside of therapy, in his daily life and in his interactions with the people that form his customary milieu. The therapy situation itself helps to unfreeze existing attitudes and behavior patterns and to extend the patient's repertory, to bring out new behaviors and emotional experiences around which new insights can be built. But the pay-off of such corrective emotional experiences comes when the insights derived from them are transferred to real life. Thus, there is a second phase of behavior change to which the therapist and the group must address themselves: they have to exert influence on the patient's behavior outside of the therapy situation. This must be done in order to make certain that he will apply the therapeutic insights to those situations in which his actions are self-defeating, his perceptions distorted, and his interpersonal relationships unrewarding.

According to the usual model of therapy, the therapist does not intervene in the patient's real life situation in any direct way. The only point at which he enters into the patient's life is during the therapeutic interactions themselves. Nevertheless, therapist and group do exert influence on the patient's real-life behavior by encouraging him (implicitly or explicitly) to try out new patterns, by providing him with a frame of reference for analyzing his own behavior, and by reviewing with him some of his attempts to apply therapeutic learnings to his interactions outside. I am speaking here of ways of influencing the patient's outside behavior while he is still in therapy. Needless to say, if therapy has been successful, its effects will continue to manifest themselves after it has been terminated, as the person applies both the process and the insights he derived from therapy to more and more of his life experiences. This would presumably happen to the extent that internalization has taken place. My concern at the moment, however, is not with these self-activated changes in the patient's behavior that represent the aftermath of effective therapy but with the direct influence on the patient's behavior outside of the therapy situation *while therapy is still in progress*. While most therapists do concern themselves with extra-therapy behavior, there are differences in how much they emphasize it and how explicit they are about it. In some therapeutic approaches, the emphasis is placed entirely on the interaction in the therapy situation proper. Real-life matters are regarded as almost irrelevant. In other approaches, there are deliberate attempts to bring in real-life experiences, to encourage transfer from what happens in therapy to what happens outside (e.g., to encourage the patient to try out new behaviors), to review the patient's

attempts to apply new insights—in short, to use the therapeutic situation as a *deliberate* training facility for real life.

It should be noted that these two phases of change may also represent competing demands. The very features of the therapeutic situation and of the techniques employed by the therapist that are most conducive to unfreezing old behavior and “getting out” new behavior *during* the therapy sessions may, at the same time, interfere with the generalization of this behavior. For example, the more isolated the therapy situation is from real life, the more it is structured as a playful situation which “doesn’t really count,” the more likely it is that the patient will feel free to experience and express emotions that he finds too threatening in the outside world. By the same token, however, it will be more difficult to generalize what he learns in this situation to real life, where the threatening features are present in full force and where everything does count. Similarly, to the extent that the therapist encourages a view of the therapy situation as the predominant focus of the patient’s life, to the requirements of which all other life requirements must be subordinated while therapy is in progress, he will increase the power of the therapeutic situation for controlling the patient’s behavior within it. This kind of emphasis may prevent a diffusion of transference, a premature acting-out in real-life contexts, or an escape from the analysis of the person’s own neurotic problems to an examination of the reality problems of his environment. At the same time, however, by keeping the therapy situation “pure,” one reduces its power to induce changes in the patient’s behavior outside of therapy. Thus, a major challenge in all forms of psychotherapy is to find the proper balance between forces toward change in within-therapy behavior and forces toward change in extra-therapy behavior. In this connection, there may be some interesting differences between group and individual therapy. Group therapy may be less powerful in the unfreezing of old behavior and the “getting out” of new behavior, but it may be more powerful in the generalization of therapeutic insights to real life. I would not want to push this proposition too far, without considerable qualification, but it may represent one major dimension of difference.

I would like to propose that compliance, identification, and internalization play a part in each of the two phases of behavior change with which therapy is concerned, i.e., changes within and changes outside of the therapy situation, and contribute to the achievement of a therapeutic effect. In the remainder of this paper, I shall try to show how each process enters into the induction of therapeutic change. Looking first at the patient’s behavior within the therapy situation, I shall take the three processes in order and, for each, discuss (1) what type of patient behavior, relevant to a therapeutic outcome, is induced by that particular process; (2) what the

therapist's role is in the induction of this particular behavior; and (3) what the group's role is in the induction of this behavior, i.e., how it may reinforce (or possibly reduce) the therapeutic potential of the situation. I shall then proceed to present a parallel analysis of the patient's behavior outside of the therapy situation.

I should mention here my assumption that, even in group therapy, the therapist is of necessity the primary influencing agent, although the group can make some powerful and unique contributions to the process.

INFLUENCE DIRECTED TO BEHAVIOR WITHIN THE THERAPY SITUATION

The influence attempts directed to the patient's behavior within the therapy situation are summarized in Table 2. It is proposed that three types of patient behavior have to be induced within the therapy situation in order to facilitate therapeutic change, and that these correspond, in the main, to the three processes of influence.

TABLE 2

Types of Influence Involved in the Production of Therapeutic Change

A. Processes of Influence Directed to the Patient's Behavior Within the Therapy Situation

	Type of patient behavior induced by this process	Therapist's role in the induction of this behavior	Group's role in the induction of this behavior
Compliance	Engagement in the therapeutic work (obeying the "basic rule")	Trainer	Sanctioning agents
Identification	Commitment to the therapeutic situation	Accepting, permis- sive, expert listener	Facilitating agents; comparison reference group
Internalization	Occurrence of corrective emotional experiences	Transference object	Interaction objects; role reciprocators

1. *Engagement in the Therapeutic Work.*

If the therapeutic business is to be transacted effectively, the patient must engage in the therapeutic work. He must be trained, as it were, to produce some kinds of behavior and to eschew others in the therapy situation. If he fails to do so, he does not provide the necessary openings for therapeutic interventions and makes it impossible for corrective experiences to emerge. Thus, in analytically oriented therapy, the patient must

allow himself to experience certain feelings despite strong resistances to them and he must express these feelings; he must be trained to talk, to free-associate, to obey the "basic rule."

Almost invariably some degree of compliance is necessary at this stage of therapy. The patient, of course, brings a certain amount of self-activated motivation to the situation, based on his desire to benefit from therapy. Nevertheless, the resistances to engaging in the therapeutic work are so strong that some extraneous motivation has to be brought into play, at least at the beginning. This motivation derives from the patient's desire for the therapist's approval and the avoidance of his disapproval. The patient's concern with a favorable reaction from the therapist constitutes a potent force in overcoming his strong resistances and getting him to proceed with the therapeutic work.

The therapist's role in this part of the process is essentially that of a *trainer*, who responds to the patient's productions in such a way as to increase the probability that what he considers therapeutically relevant material will emerge. Analysts and particularly nondirective therapists would not like to think of themselves as engaging in such deliberate training. But they do—and in fact have to—train the patient, even if they are unaware of it. The therapist often, in subtle ways, directs the patient; he approves of some things and disapproves of others. The patient picks this up and tailors his subsequent productions accordingly. For example, in analytic therapy, the therapist makes the patient uncomfortable about his resistances by confronting him with them, interpreting them, etc., until they gradually become less frequent. Also, he encourages certain kinds of contents, in contrast to other kinds, by responding to them, showing interest in them, and building interpretations around them. Patients learn to give the therapist what he seems to want. In nondirective therapy, the therapist shows approval by reflecting, reacting to a particular line, and picking up some contents while neglecting others. The research on verbal conditioning (cf. Greenspoon, 1955; Krasner, 1958) has shown that in *non-therapeutic* situations, individuals are responsive to slight cues of approval, such as the sound of "mm-hm." Since the therapist's reactions are so much more important to the patient and since the patient finds himself in a relatively ambiguous situation in which he is searching for guidelines for his behavior, it seems more than reasonable to assume that he will be sensitive to subtle cues of approval or disapproval emanating from the therapist. The work of Murray (1954, 1956) is consistent with this assumption.

I do not for a moment want to equate this part of the process with the therapeutic process as a whole. My view of therapy, as should be clear from everything I have said and will say, is completely inconsistent with the

notion that it is all "just a matter of verbal conditioning." I am only proposing that the kind of training I have described, which is based primarily on the therapist's ability to supply or withhold approval in this ambiguous, anxiety-laden, and delicate interpersonal situation, represents an essential step which mediates therapeutic change. Inducing the patient to experience feelings and to talk about them is a prerequisite for the occurrence of therapeutically relevant events. Moreover, inducing the patient to talk about the particular contents and in the particular language that are required by the therapist's theory provides the terms within which this particular therapist can become useful to the patient. While compliance, then, is strictly a mediating step, it may happen that a patient becomes fixated at that level, i.e., that he adopts the language overtly and superficially and does not go beyond that. He says all the right words, even though they do not correspond to his actual feelings and are not used in an attempt to develop more appropriate labels for his behavior. Typically, this represents an elaborate form of resistance to the therapeutic process rather than a way of bringing it forward. By complying with the letter rather than the spirit of the therapist's requests, the patient avoids real engagement in the situation. Overcompliance, as a matter of fact, may represent a form of hostility.

Turning to group therapy, in what way does the group contribute to this part of the therapeutic process, to inducing the individual group member to engage in the therapeutic work? The group members can serve as additional *sanctioning agents* who can apply various kinds of pressure on the individual patient to conform to the requirements of the situation and engage in the therapeutic work. If the requirements to express one's feelings, to say what is on one's mind, etc., are adopted as part of the group's norms, the training process that I have described can be considerably reinforced and speeded up. The group has powerful techniques at its disposal for controlling the behavior of individual members and maximizing their conformity. Desirable behavior can be rewarded by praise, encouragement, support, or by giving the individual visible signs that he is a valued member of the group and that his status is secure and may, in fact, be enhanced. Undesirable (nonconforming) behavior can be discouraged by direct criticism, ridicule, ostracism, loss in status, and other signs of rejection. Small-group studies, both in the laboratory and in industrial settings, have provided demonstrations of the group's power to control member behavior through the selective application of encouragement and pressure. This clearly represents a potentially powerful source of influence.

A group's ability to induce compliance to its norms depends on its control over resources that are important to the individual. In the case of therapy groups, the resources that are at stake are not of a material but of a psychological nature. A member will be likely to comply with the group's

demands to the extent that he depends on this particular group as a source of acceptance and approval. It can be assumed that for most patients this dependence will be rather high for two reasons: first, because they are likely to be low in self-esteem and thus need external support to bolster it; second, because they are likely to lack close interpersonal relationships and involvements in rewarding group interactions. For many patients the therapy group may fulfill a unique function, not by virtue of the therapeutic process that it sets in motion, but simply by virtue of the sustained and meaningful social relationships that it makes possible for them, thus filling a void in their daily lives. It can be assumed that the group's control over this particular type of patient will be especially strong. One might also predict that this type of patient would be most likely to remain fixated at the level of compliance. To the extent that remaining a member in good standing of this group and obtaining immediate satisfactions that derive from group membership satisfy major needs for him, he may be both more motivated to protect his status in the group and less motivated to get deeply involved in the therapeutic process itself: he already has what he most wants, provided the group continues to accept him.

The group's ability to induce compliance also depends, of course, on some of the characteristics of the group. For example, if the group has built up the sanctioning function by actively encouraging and approving conforming behavior and actively discouraging and punishing nonconformity to its norms, its means-control over the individual member will be stronger. Means-control depends not only on the extent to which the group controls important resources, but also on the perceived probability that it will use this control to insure compliance. A group that actively uses this sanctioning function can make an important contribution to the therapeutic business by inducing the patient to engage in the therapeutic work. It must be kept in mind, however, that the group's power in this regard is a double-edged sword. It can be used for the furtherance of the therapeutic process, but it can conceivably also be used for resistance to it. In experimental and industrial groups it has been found that group pressure can be very effective in inducing members to conform to a particular standard of productivity. This, however, may take the form of increasing or decreasing an individual's level of productivity, depending on the particular nature of the group standard (Coch and French, 1948; Schachter et al., 1951; Berkowitz, 1954). Similarly, in group therapy, if group norms develop that encourage resistance to the therapeutic process, the group may strengthen antitherapeutic forces. Frank (1957) points out that this is unlikely to happen, because the therapist himself is the only stable source of norms for the group. Be that as it may, it is still necessary for the therapist to concern himself with the nature of the group norms that develop. He cannot leave this

entirely to chance, but must bring his unique influence to bear in such a way that the group norms will support engagement in the therapeutic work rather than resistance to it.

2. *Commitment to the Therapeutic Situation*

The sanctions applied by the therapist and the group may be powerful instruments in inducing the patient to conform to the therapeutic norms, but their effectiveness depends on the patient's motivation to remain in therapy. If this motivation is low, then he will simply remove himself from the situation as soon as the level of anxiety created by the experience and disclosure of his feelings becomes too high. If the patient, then, is to continue in therapy long enough so that he can get to the point of having corrective emotional experiences, he must develop a commitment to the therapeutic situation as one that is potentially beneficial to him and for which it is worth making certain sacrifices. This attitude of commitment is particularly essential since, for most patients, therapy is a strange and ambiguous situation, which violates many of their initial expectations and whose benefits are by no means clear to them. Even under the best of circumstances, it takes some time for any beneficial effects to become apparent, and the patient needs this sense of commitment to sustain him in the interim.

There is another sense in which commitment to the therapeutic situation is essential. The patient must come to view it not only as a situation which is beneficial to him in the long run, but also as one that is safe for him in the "short run." When he is asked to conform to the therapeutic norms by exposing himself and expressing his feelings without censorship, he is placed in a very difficult situation. He runs the risk of criticism, rejection, and condemnation after he has divested himself of his defenses and laid himself bare before others. If the patient is to feel free to engage in the therapeutic process and talk about himself, then he must regard the situation as one in which he is safe from attack and condemnation and in which he can afford to relax his customary protective mechanisms. In short, then, if the patient is to engage himself in the therapeutic process and open himself to the possibility of therapeutic experiences, he must develop a commitment to the situation: an attitude of trust and a willingness to accept its terms, based on his conviction that he will be protected in this situation and that he will benefit from it.

These attitudes to the therapeutic situation, I propose, are induced primarily through the process of identification with the therapist. A patient typically establishes a relationship to the therapist that provides him with a more satisfying self-definition than the one with which he entered

therapy. Through his relationship to the therapist, the patient's self-esteem is enhanced: he comes to see himself as a person who is worthy of attention and acceptance. Moreover, as a consequence of this relationship, he gradually loses his sense of hopelessness about his fate and sees himself as a person who is successfully moving toward a resolution of his conflicts. It is as part of this satisfying self-defining relationship to the therapist that the patient's commitment to the therapy situation as a whole develops. Trust in the therapy situation and acceptance of its terms represent the expectations that circumscribe the patient's role in this reciprocal relationship. To the extent that the patient wishes to maintain this relationship, he will tend to adopt the attitudes expected for his role within it. Freud's (1950) concept of the conscious component of positive transference refers, essentially, to this process of commitment to the therapy situation through identification with the therapist.

The therapist's contribution to this process consists in offering the patient a relationship that will enhance his self-esteem and his feeling of hope. He accomplishes this largely by adopting, as his part of this reciprocal relationship, the role of an *accepting, permissive, expert listener*. Most schools of therapy stress that an essential part of the therapist's role is to communicate to the patient a full understanding and unconditional acceptance of him. Regardless of what the patient may reveal about himself, the therapist does not judge or condemn him. Rogerian therapy places primary emphasis on the attitude of acceptance conveyed by the therapist and regards it as not only a necessary, but actually a sufficient, condition for therapeutic change (Rogers, 1957). In analytically oriented therapy, the emphasis is not so much on acceptance of the patient as a person as it is on permissiveness in the sense of reassurance that no feeling the patient might express and no revelation he might make will lead the therapist to condemn or reject him (cf. Menninger, 1958). Despite differences in emphasis, most schools of therapy do view some form of acceptance as a necessary part of the therapeutic relationship, as Fiedler's (1950a and 1950b) research tends to demonstrate. This aspect of the therapist's role, which tends to enhance the patient's self-esteem and provide him with a more satisfying self-image, certainly forms part of the basis of the patient's identification with the therapist.

A second feature of the therapist's role, which greatly contributes to inducing a commitment to the therapy situation in the patient, is the therapist's apparent expertness and related characteristics designed to inspire faith in his ability to help the patient. Frank (1959) has provided a most illuminating discussion of the variety of factors that promote this kind of faith in the therapist and of the way in which faith enters into the therapy process. The main point in the present context is that, to the extent that

the therapist inspires faith, the patient's relationship to him reduces his sense of helplessness and enhances his feeling of hope. The resulting identification with the therapist, in turn, increases the patient's commitment to the therapy situation and to his own role requirements within it.

In most forms of therapy, this part of the therapeutic process is regarded as a means to therapeutic experiences, not as an end in itself. In analytically oriented therapy, in particular, positive transference is important only in that it provides motivation for the patient to continue with the therapeutic work despite its painfulness, and in that it creates an atmosphere in which the patient feels safe and free to examine his feelings. As a matter of fact, analysts, like Menninger (1958), stress the necessity of limiting the amount of satisfaction that the patient derives from his relationship to the therapist: it must be sufficient to keep him in the situation, but not so much as to make it an end in itself and thus reduce the patient's motivation to engage in the therapeutic process. Even Rogerians, who put primary emphasis on acceptance, do not regard this as the end of therapy. They merely regard it as the limit of the *therapist's* contribution, but this is only a means to the therapeutic process itself, which is essentially the patient's own responsibility. It often happens, however, that the therapeutic process becomes fixated at the level of identification, that establishing a self-defining relationship to the therapist becomes an end in itself rather than a step that mediates the occurrence of corrective, insight-producing experiences. This is the kind of outcome that is sometimes referred to as a "transference cure," which has similar dynamics to placebo cures and faith healing, as described in detail by Frank (1959, 1961). Such an outcome may, in fact, be quite meaningful therapeutically, depending, of course, on the criteria one uses. The opportunity of establishing a relationship with the therapist—by giving the patient something to hold on to, someone in whom he can have faith, on whom he can depend and on whose acceptance he can count—may help to stabilize the patient's self-concept, provide him with a sense of identity (even if it is a borrowed identity), and thus change the whole balance of his life. Thus, solely on the basis of the relationship to the therapist, without any special insight or working-through, the patient may manifest changes in his self-attitudes and, related to these, an increase in general feeling of comfort and symptomatic relief.

Now let us turn to group therapy and examine the way in which the group contributes to this part of the therapeutic process, to inducing the patient's commitment to the therapy situation and to his own role requirements within it. Other group members serve, in various ways, as *facilitating agents* who make it easier for the individual patient to continue with the therapy process and to take the risks of self-revelation. The patient's relationship to the group typically provides him with a more satisfying self-

definition because it enhances his self-esteem and lowers his sense of helplessness. In these respects, the group does not merely reinforce the effects of the therapist but makes certain unique contributions that the one-to-one relationship to the therapist cannot offer.

First, the group can help to overcome the patient's feeling of isolation, which is, of course, a central problem for many neurotic patients. The very feeling of belonging to a group is in itself a source of self-esteem (Frank, 1957), which is further bolstered by the experience of intimacy and support from others. Of particular importance is the fact that this is a group of individuals with similar or related problems (cf. Beck, 1958), which gives the patient the reassuring feeling that his situation is not unique and unprecedented. The presence of shared problems and a common fate increases the likelihood of identification with the group, which in turn increases the patient's commitment to the therapy situation as a whole.

A second contribution of the group to a more favorable self-definition of the individual patient is based on its acceptance of him, despite his "obvious deficiencies, lack of status, and intimate revelations" (Beck, 1958). Needless to say, such acceptance enhances the patient's self-esteem as well as his feeling that he can somehow be reclaimed. While acceptance from the group is not as predictable nor as unconditional as that from the therapist, when it does occur it is likely to have a powerful impact. For here is acceptance not by a professional, who has been trained to take this role and is being paid for it, but by the person's own peers who, despite their deviancy, are more representative of society at large.

A third contribution of the group in the present context is based on the fact that it can serve as a *comparison reference group* for the individual patient, i.e., as a group that he can use as a standard for comparison in evaluating his own fate and his own progress. By comparing himself to others whose situation resembles his own, the patient can gain a certain degree of hope and encouragement. His difficulties seem less devastating when he can use a group of fellow-patients as his reference group, rather than his associates from his daily environment (cf. Beck, 1958). Moreover, as other patients show progress, the patient's optimism about his own situation may (at least up to a point) be enhanced.

In short, by relieving the patient's sense of isolation and deviance, by offering him support and acceptance by his peers, and by providing him with encouraging points of reference, the group can greatly enhance his commitment to the therapy situation. The increased self-esteem and hope generated by his relationship to the group help in motivating him to continue therapy and in freeing him to express himself despite the risks this entails.

The satisfying self-definitions that patients derive from their relation-

ship to the group have not only a direct but also an indirect facilitative effect on their commitment to the therapy situation. These and other satisfactions provided by the group contribute to the general cohesiveness of the group, i.e., "the resultant of all the forces acting on all the members to remain in the group" (Cartwright and Zander, 1960, p. 74). Numerous studies have shown that the greater the cohesiveness of a group, the greater its ability to induce change in the members, not only at the level of public conformity but also at the level of private belief. That is, the more cohesive the group, the more likely are the members to accept the attitudes that it prescribes—which, in the case of therapy groups, would include a favorable attitude to the therapy situation. Among the potential sources of cohesiveness in therapy groups, Frank (1957) mentions the extent to which the group provides direct satisfaction for some of the members' needs and promises future satisfactions, the extent to which members find that they can be mutually helpful to each other, the extent to which the group provides rewards for successful performance, and the extent to which mutual attraction of members develops.

If the group is highly cohesive, there is, of course, the possibility that the individual patient will become committed to the group *per se* rather than to the therapeutic process. In that case, the patient would remain fixated at the level of identification with the group: that is, the satisfying relationship to the group would become an end in itself rather than a means to further self-examination and insight-producing experiences. As I pointed out earlier, such an outcome may be therapeutically quite meaningful in that it may, by enhancing the patient's self-esteem, restore the balance of his life situation. Typically, however, it would be up to the therapist to make sure that the patient's relationship to the group serves as a spur to the therapeutic process rather than as a substitute for it.

There is another danger inherent in group therapy to which the therapist must always remain alert. The facilitative effect of the group is predicated on the assumption that the group will accept the individual member as he is. If the member is confronted, however, with condemnation and rejection, the experience may be antitherapeutic, his commitment to the therapy situation may be reduced, and he may eventually withdraw from the situation completely. This does not mean that acceptance of others has to be complete. As a matter of fact, there is some experimental evidence (Dittes and Kelley, 1956) to the effect that, under certain circumstances, the member who is not fully accepted in the group is more likely to become committed to its norms than the one whose acceptance is very high. Moreover, criticisms and attacks from the group may on occasion initiate therapeutically useful experiences (Frank, 1955, 1957). There must, however, be an underlying atmosphere of acceptance and support by the group, so that

the patient will not regard an occasional attack as complete rejection, and so that there will be the definite prospect that, as he changes his behavior, acceptance will be restored. It is up to the therapist to foster an atmosphere of mutual acceptance as part of the normative structure of the group and to step in to protect the individual patient when this norm is seriously violated.

3. *Occurrence of Corrective Emotional Experiences*

The experience and expression of feelings in the therapy situation, which are encouraged through deliberate training by the therapist and identification with him, are designed to provide opportunities for the occurrence of "corrective emotional experiences" (Alexander and French, 1946). Such experiences are based on the manifestation, right in the therapy hour, of the distorted, self-defeating, and troubling attitudes that the patient brings to his real-life relationships. The conditions for a corrective emotional experience are present if the feelings the patient experiences when he expresses these attitudes in the therapy situation are as real and intense as they are under usual circumstances. The difference between the therapy situation and other situations is, of course, the fact that in therapy he is able, and in a way forced, to examine these feelings as they occur, which he cannot do in real life. With the help of the therapist, the patient can thus begin to see his attitudes in their true light, he can recognize their distorted and self-defeating aspects, and he can gain some understanding of their origins. Typically, the therapist is able to confront the patient with the inappropriateness of his attitudes by reacting in ways that violate the patient's expectations. A clear disconfirmation of a clear expectation provides the raw material for a re-examination of the patient's unrealistic attitudes and inappropriate feelings.

The essence of a corrective emotional experience is the fact that the patient's examination of his attitudes and behavior patterns occurs simultaneously with their actual manifestation at a real-life level of emotional intensity. He examines his attitudes and behavior while he is still experiencing the relevant feelings, which makes this more than a mere intellectual exercise. The unique value of psychotherapy is that it makes this simultaneous occurrence of real feelings and their examination possible. Outside of therapy, situations in which strong feelings occur are precisely those in which examination of these feelings—stepping aside and observing one's self objectively—is impossible. When a person does examine his behavior objectively, it is generally after he has gained some distance from it and it has been drained of its emotional intensity.

Corrective emotional experiences can form the basis for internalized changes in the patient's conceptions of the self and of interpersonal rela-

tionships. As a result of these experiences, and the therapist's interpretations, the range of information that is available to the patient becomes widened. He gains new insight, a new understanding of the attitudes that he characteristically brings to his interpersonal relationships, of the behavior patterns that result from them, and of the expectations of others' reactions that generally guide him. Out of these new insights, more realistic attitudes and expectations can develop. We can speak of internalized changes here because corrective emotional experiences represent a re-examination of the patient's attitudes and behavior in the light of his own value system. The changes that emerge from such experiences are presumably integrated with his value system: the patient abandons self-defeating attitudes and behavior patterns and, instead, learns to see himself and others and to behave interpersonally in ways that are more likely to maximize his own values.

Sometimes, a series of corrective emotional experiences may lead, not only to changes within an existing value framework, but actually to changes in basic values themselves, that is, the patient may come to adopt new values that are more realistic for him. Ideally, however, even when this happens, there would be some continuity between the new values and his self-system. Values communicated by the therapist would serve as catalysts and models in the re-examination of the patient's values, but the patient would not simply take them over *in toto*. He might adopt the therapist's values in modified form, in ways that meet his own needs, temperament, and life history. It may, of course, happen that a patient simply takes over the values of the therapist. This would be a case of therapy having been fixated at the level of identification. A genuine corrective emotional experience, however, implies a confrontation between the patient's current attitudes and behavior and his own value system. Changes resulting from such an experience should, therefore, be changes at the level of internalization.

As has already been noted, compliance and identification are usually necessary before such corrective experiences can occur. Often, the three processes represent sequential steps in the therapeutic process. The patient starts out by complying: he follows the basic rule and engages in the therapeutic work, at least in part, for short-range rewards at the beginning stages of therapy. Identification then enters in, in two ways: the patient must get some satisfaction out of the relationship to the therapist as such, in order to continue in therapy; and, if the therapeutic situation is to offer some novelty, he must be able to take over the therapist's point of view, at least on an experimental basis. As he continues to engage in the therapeutic process, corrective emotional experiences can occur and internalized changes can be built on them.

The therapist contributes to this part of the therapeutic process by confronting the patient with the distorted and self-defeating character of his attitudes and behavior, by offering interpretations, and in other ways encouraging the patient's examination of himself. There is another important contribution, however, that the therapist makes to this part of the therapeutic process: he is frequently the *object* of a corrective emotional experience. One of the major sources of emotional experiences in therapy is the patient's relationship to the therapist. In the context of this relationship, the patient can feel anger, dependency, anxiety about loss of love, sexual attraction, and a whole host of other emotional reactions. Feelings toward the therapist are the most likely to be experienced at their full intensity because they are immediate and directly related to the present ongoing situation. Thus, these feelings are most likely to form the basis of corrective emotional experiences. Essentially, then, the therapist serves as *transference object*, if we use this term more broadly than in its strictly psychoanalytic meaning. In part, it can be assumed that the patient transfers to the therapist attitudes and feelings that are irrelevant to the present situation, that are merely repetitions of patterns based on childhood relationships or of patterns carried over from the patient's present interpersonal relationships outside of the therapy situation. In part, the patient's attitudes and feelings toward the therapist may represent direct reactions to the therapist as a person or to the role that he enacts. Even though the therapist tries to be neutral, he does reveal his personality and attitudes in some ways, and these may stimulate some of the patient's characteristic patterns. Moreover, neutrality as such is also a definite role which can elicit some of the patient's interpersonal reactions. For example, the patient may interpret the therapist's neutrality as lack of interest and lack of concern for him, and he may proceed to manifest his characteristic patterns for situations thus interpreted. Regardless of whether the patient's emotional reactions to the therapist are based "purely" on transference or whether they are based on the patient's interpretation of the realities of the situation, they reveal some of the patient's characteristic patterns of interpersonal behavior at a realistic level of emotional intensity and thus provide current material for corrective experiences.

In group therapy, the group has a special contribution to make to this part of the therapeutic process. The group situation provides many possibilities for stimulating the patient's habitual interpersonal reactions, which can then be examined and form the basis for corrective emotional experiences (cf. Frank and Ascher, 1951; Beck, 1958). The great advantage of the group over the individual therapist in this regard is that it makes available a wide range of *interaction objects* to the patient, thus increasing the chances that the attitudes and patterns that trouble him in real life

will come into play during the therapy hour. In individual therapy the possibilities are limited. The therapist is only one person, and moreover a person who enacts a very special and unusual role, marked as it is by affective neutrality (Beck, 1958). This does not mean that he fails to arouse emotional reactions, particularly since the opportunity for transference is ever-present, but in the group the opportunities are much more extensive. For one thing, there may be a wide range of social statuses represented: members are likely to vary in sex, age, social class, education, occupation, family position, etc. Thus, there are more opportunities for the patient's unrealistic and inappropriate attitudes to be stimulated in the therapy situation. For example, if a patient has problems in his relations with women, or with authority figures, or with peers, it is likely that these will manifest themselves as he interacts with the group members who represent these statuses. Moreover, the group is likely to represent a range of personality styles, interpersonal patterns of behavior, and general attitudes. Thus, again, it offers many opportunities for stimulating the patient's characteristic reactions. If, for example, his neurotic attitudes are most likely to be aroused when he deals with people who are more aggressive than he is, or more confident than he is, etc., chances are that the group will make such interactions available.

A third reason why there is likely to be more stimulation of habitual patterns in the group situation is that it brings into play a wider range of current issues that generate emotions at a real-life level of intensity. The patient is involved in a real group situation, even though this is an atypical group. This situation, like other group situations, is marked by competition for the leader's attention, struggles for power and status within the group, attempts at saving face and making a good impression, requests for help and offers of help, and so on (cf. Varon, 1953). This range of interpersonal issues with which the group members are constantly concerned is likely to stimulate the patient's characteristic attitudes and behavior patterns at a high level of intensity and make them available for examination. The stimulation provided by the here-and-now issues of group interaction is further enhanced by the fact that these bring into play a variety of informal roles and interpersonal patterns, distributed over the members of the group. This happens partly because these situations elicit characteristic behavior patterns that patients bring to their interpersonal relationships (cf. Frank et al., 1952), and partly because the inherent dynamics of group functioning make some degree of role differentiation necessary. Thus, as any given patient deals with the real and current interpersonal issues activated by the group situation, he is confronted with a range of role behaviors on the part of other group members that can serve to instigate, complement, and reciprocate his own reactions.

In sum, one of the major advantages of group therapy is that it provides numerous opportunities for eliciting affect-laden reactions on which corrective emotional experiences can be based. The group accomplishes this by generating significant current issues around which interactions can occur, and by offering each patient a wide range of interaction objects—varying in social status, characteristic interpersonal behavior, and informal group role—capable of bringing out his habitual attitudes and behavior patterns. Thus, the patient's reactions to a wide variety of interpersonal stimuli become directly available for examination at the very moment that they are occurring. The range of possibilities is further extended by the fact that the patient can have some vicarious corrective emotional experiences by observing the behavior of others and its interpretations and applying these to his own case. While this is clearly not at the same level of emotional intensity as a corrective experience in which he himself is the main actor, his identification with the other patient may give the experience an emotional impact. Such experiences may be useful forerunners to more direct corrective experiences for which the patient may not yet be ready. In the group situation there is, thus, a ready-made mechanism for graduating the intensity of the experience. Furthermore, corrective emotional experiences in a group situation typically involve supporting actors in addition to the main one. While one patient's reactions may be the focus in a given situation, the examination of his reactions may also reveal how others have elicited it and contributed to it. Patient B may thus learn something from patient A's corrective experiences, particularly about his own stimulus value and the effect he has on others.

This leads us to another special contribution that the group can make to the analysis of corrective emotional experiences. When the patient manifests a troublesome interpersonal attitude or behavior pattern, he can be confronted not only with the distorted and self-defeating character of the behavior itself but also with the reactions it elicits in others. In individual therapy, such confrontation is limited. The therapist does not react spontaneously, but tends to remain neutral. He can only inform the patient of the kind of reaction this behavior is likely to elicit in others. In group therapy, the reactions of others are present here and now. They are produced spontaneously by fellow-patients, can be observed directly by the patient and the therapist, and thus constitute part of the experience available for analysis. The other patients can also confirm and support the therapist's interpretations by describing their own reactions to the patient's maneuvers. The patient is thus able to obtain a fuller and more dramatic picture of the nature and meaning of his behavior, since he is immediately confronted with the impact it has on others. For example, he can be shown convincingly that the way he reacts to an offer of help is calculated to alienate

others at a time when he most needs them. Similarly, his distorted perceptions of others can be examined effectively since these others are personally present. For instance, he may act on the assumption that others will disdain him if he reveals too much dependency; this expectation can be refuted by the way others in fact react to him and by the way they describe their own reactions in subsequent examination of the relevant event.

The fact that, in group therapy, the reactions of others are included in the corrective emotional experience not only provides a fuller picture of the patient's characteristic behavior for analysis but also increases the similarity between the event in the therapy hour and the real-life situations in which the patient experiences difficulty. The patient's ability to build on this experience, to relate it to his daily life, to find examples that fit what he has just learned, and to note how his interpersonal behavior in daily life prevents maximization of his values is therefore increased. The process thus initiated may lead to internalized changes in the patient's conceptions of himself and of interpersonal relations that go beyond the therapy situation.

The group's ability to stimulate and enhance the realism of corrective emotional experiences depends, in large part, on the heterogeneity of its composition. The opportunities for such experiences will increase if the members of the group represent a range of social statuses and personality types, thus providing a variety of potential interpersonal stimuli. At the same time, however, there must be enough homogeneity in the group so that it can constitute a reasonably representative social unit. If the cultural backgrounds of the members are extremely varied, it is less likely that complementary patterns will mesh and characteristic reactions will be elicited. Similarly, the reactions of others, who are clearly from a different milieu, do not have as much of an impact on a patient who is confronted with them. In short, then, from the point of view of maximizing opportunities for corrective emotional experiences, there should be as much heterogeneity as possible, within the limits of the range of people with whom the patient is likely to interact in his daily life. Of course, other considerations have to enter into the determination of group composition. From the point of view of increasing the patient's commitment to the therapy situation, as discussed above, a certain degree of homogeneity is necessary: the patient must see the other group members as similar to himself and sharing some of his problems. Here too, however, complete homogeneity is neither necessary nor desirable. Optimally, there should be a communality of fate in some important respects but differences in personality, background, and so on. These requirements can generally be met by including in the same group patients with a variety of neurotic symptoms. Even in those cases, however, in which it is considered desirable to maintain homogeneity of

symptoms because of the special nature of the problems engendered by these symptoms, e.g., in groups of alcoholics, it would be best to aim for heterogeneity in all respects other than the defining symptom.

The group therapist's responsibility with respect to this part of the therapeutic process is to serve, as it were, as the director of the corrective emotional dramas that the patients act out. He must be alert to the interactions between the patients in order to guide them and use them as bases for corrective experiences. In this connection, it is important for the therapist to be sensitive to the dynamics of the group process itself, so that he will be aware of some of the immediate forces that determine the patients' behavior and the here-and-now issues with which they are concerned. Group therapists do not always take into account the character of the group as an actual functioning unit in which meaningful interactions are going on. Yet, these interactions offer some of the best opportunities for insight-producing confrontations.

INFLUENCE DIRECTED TO BEHAVIOR OUTSIDE OF THE THERAPY SITUATION

Changes produced within the therapy situation certainly have an important bearing on the patient's behavior outside. Thus, changes resulting from corrective emotional experiences, insofar as they are internalized changes, should, by their very nature, be generalized to the patient's interpersonal relationships in daily life. Similarly, some of the changes produced by identification with the therapist or the group may go beyond the therapy situation: they may enhance the patient's self-esteem and faith sufficiently to help him through a critical period, at which point his normal coping mechanisms can again come into play. In the course of the therapy situation itself, however, there are also *direct* attempts at exerting influence on the patient's behavior outside of therapy. Here again, all three processes of influence may be involved. This part of the argument is summarized in Table 3. I am proposing that three types of extra-therapy behavior must be induced in the patient during therapy in order to facilitate therapeutic change, and that these correspond, in the main, to the three processes of influence.

1. *Experimentation with New Actions*

Generalization of therapeutic learnings to the patient's real-life situations requires, first of all, that he experiment with new behaviors. Only as he tries to change his actions in interpersonal situations can he become fully aware of the unrealistic nature of his earlier attitudes and gain the necessary confidence to reorient his characteristic patterns. Such experi-

TABLE 3

Types of Influence Involved in the Production of Therapeutic Change

B. Processes of Influence Directed to the Patient's Behavior
Outside of the Therapy Situation

	<i>Type of patient behavior induced by this process</i>	<i>Therapist's role in the induction of this behavior</i>	<i>Group's role in the induction of this behavior</i>
Compliance	Experimentation with new actions	Imaginary interlocutor	Anticipated audience
Identification	Adoption of the therapist's and/or group's standpoint for viewing the self and inter- personal relations	Role model; norm setter	Normative reference group
Internalization	Generalization of therapeutic in- sights to specific real-life situations	Auxiliary reality tester	Representatives of society

mentation, of course, continues to take place after the patient has terminated therapy, but it is important that it begin while therapy is still in progress. At that point, the patient's experimentation can be based on therapeutic experiences that are still fresh in his mind; it can be brought back to the therapy situation for further review; and it can be carried out under conditions of greater protection, i.e., with the support of the therapist and the group and the assurance that the patient can always turn to them in the event of failure.

Typically, experimentation with new behavior develops out of corrective emotional experiences and represents attempts to generalize new insights to specific real-life situations (see section 3, below). Such experimentation, however, usually does and should begin earlier in the course of therapy. It is sometimes possible to induce a small but significant change in the patient's interpersonal behavior simply by pointing out to him that other actions are possible and socially acceptable and encouraging him to try them. Such changes can occur with very little prior insight, but they can become an important source of subsequent insight: after having tried out the new behavior, the patient will be in a better position to examine the causes for his earlier difficulties and the possibilities for overcoming them. Moreover, such experimentation, if successful, may increase the patient's self-esteem and commitment to the therapy situation as a potentially useful experience. For these reasons, there is therapeutic value in inducing the patient to experiment with new behaviors outside—on a limited, graduated

basis—even during the early stages of therapy. At that time, the induction leans heavily on the side of compliance.

What typically happens is that the patient reviews some of his interpersonal relationships and reveals their troublesome character. As he does so, he may be confronted with explicit or implicit suggestions to change his approach in some of the specific situations that he describes. For example, if he discusses the fact that his mother-in-law constantly criticizes him and he always gets upset by these experiences, he may be told: "Next time your mother-in-law criticizes you, why don't you try to stand up to her?" Or, more likely, the encouragement to try out new behavior will be implicit. For example: "It is interesting that you never stand up to your mother-in-law when she nags at you." Along with these suggestions, the expectation is communicated (again, usually implicitly) that carrying out the suggested experimentation will produce approval by the therapist or the group, and failure to do so, disapproval. Often, the patient will react to this kind of suggestion by committing himself to trying out a new approach. When that happens, he can expect further disapproval for failure to carry out his commitment. The patient's concern with approval and disapproval may, thus, motivate him in part to carry out the suggested behaviors.

The therapist's role in this part of the therapeutic process is that of an *imaginary interlocutor*. When the patient finds himself in real-life interpersonal situations that he has discussed in a therapy session, the therapist tends to be represented as a third party with whom he engages in imaginary conversation. The knowledge that he will have to report his behavior in the next session increases the likelihood that he will live up to the therapist's expectations and to his own commitment to try out new actions. Even when a particular situation has not been specifically discussed with the therapist, the patient's behavior is likely to be influenced by the anticipated reaction of the therapist to the subsequent report of this behavior. A patient may spontaneously experiment with new behavior because (on the basis of earlier statements and reactions by the therapist) he expects the therapist to approve it. Similarly, a patient may refrain from engaging in certain behaviors that he knows or thinks are disapproved by the therapist, because he would rather not be in a position of having to report them. Thus, the requirement of reporting to the therapist everything that happens in the patient's life extends the range of the therapist's surveillance and his training function to events outside of the therapy situation proper.

The group's role with respect to this part of the therapeutic process serves to reinforce that of the therapist. Just as the group can use its sanctioning function to induce conformity within the therapy situation, it can

extend this function, to some degree, to extra-therapy behavior. The group represents, in essence, an *anticipated audience* to whom the patient must report on his behavior outside of therapy. Experimental research by Zimmerman and Bauer (1956) has shown that the way in which people organize and remember experiences is partly determined by the groups to whom they expect to report on these experiences. It seems reasonable to propose, in line with their theoretical notions, that the groups to whom the individual expects to report on his experiences will also influence the very experiences he allows himself to have. In other words, there will at least be some tendency to tailor his experiences so that their report will meet with the approval of the anticipated audience. This mechanism is likely to be operative in group therapy, and thus to increase the likelihood that the patient will experiment with new behaviors that the group has encouraged him to try or that he has reason to believe will meet with the group's approval. The group's ability to influence the patient in this direction should depend on the very same factors that determine its ability to influence the patient's engagement in the therapeutic work within the therapy situation. There is also the possibility of antitherapeutic effects if the group reinforces defensive ways of handling the patient's real-life difficulties.

To the extent that the patient's changes in his behavior outside of therapy are tied strictly to the approval of the therapist or the group, their effect will be limited. They will tend to persist only as long as direct surveillance by the therapist or the group continues. The expectation, of course, is that this experimentation with new behavior will facilitate and be tied in with subsequent insights.

2. *Adoption of the Therapist's and/or Group's Standpoint*

In the course of therapy, the patient is induced not only to experiment with new behaviors in real life but also to adopt a new frame of reference for viewing his own behavior and his relations with others. Thus, for example, he may accept the assumption that much of his interpersonal behavior is defensive in nature; or that his difficulties originate in his own attitudes rather than in an unfriendly environment; or that he is ineffective because he is caught up in neurotic interactions, not because he has a weak character. As he reacts to various baffling situations in his daily life, which previously he had been unable to understand, he can now bring this new point of view to bear on them. He is now able to see some of his problematic interpersonal patterns in a new light and to formulate them in a new language. Essentially, he has learned a new conceptual scheme or a new ideological system from which he derives hypotheses that he can apply to his behavior outside of therapy. The adoption of some new frame of reference

of this sort is essential if the patient is to have corrective emotional experiences in therapy and to carry over the insights derived from these experiences to his real-life situations. The therapeutically induced viewpoint helps to shake loose his original, and generally unproductive, way of looking at things and makes him aware of new possibilities. Moreover, it provides him with a language in terms of which he can account for what is happening and formulate new insights. It also provides a vehicle for bringing real-life experiences back to the therapeutic hour, where their interpretation can be further discussed and refined. Adoption of this frame of reference, then, is not a therapeutic end in its own right, but it represents an important conceptual tool for developing and communicating about new insights.

Typically, this new frame of reference is originally adopted through the process of identification with the therapist. I have already discussed the bases for identification with the therapist and the way in which such identification produces commitment to the therapy situation, i.e., a taking over of the therapist's attitudes toward the situation. For similar reasons and in a similar manner, the patient gradually tends to adopt the therapist's standpoint in viewing himself and his interpersonal relationships. He takes over the therapist's attitudes, including the therapist's attitudes toward the patient himself, as his own. He thus comes to formulate and judge his own behavior and the behavior of others with whom he interacts in the terms that the therapist would use.

The therapist's obvious function with respect to this part of the therapeutic process is that of a *norm setter*: he communicates the normative expectations that the patient would have to meet (outside of the therapy situation, not only within it), if the patient-therapist relationship is to be maintained. These normative expectations include the adoption, at least on a trial basis, of the therapist's ideological viewpoint. There is, however, a perhaps even more important function that the therapist performs with respect to this part of the process, namely, that of a *role model*. Typically, the therapist is attractive to the patient not simply as a partner in a reciprocal role relationship but also as an object for emulation, since he so clearly possesses all the attributes that the patient himself lacks: recognized status, knowledge about human behavior, control over the current situation, apparent mental health. The patient is motivated to become like the therapist and, in the process, to adopt the therapist's language, attitudes, and values, particularly as they relate to matters of immediate concern. Thus, he takes over the therapist's role and looks at himself and others from its vantage point. In group therapy, of course, there is a ready-made arena where this identification with the therapist can play itself out: the patients can take

on the therapist's role vis-à-vis each other, and in fact they are often helpful to each other in doing so.

Ideally, the adoption of the therapist's standpoint through identification with him represents only a transitional stage in therapy. It is therapeutically very important because the patient must find some new way of looking at things and must have some framework that he can apply to specific situations and in terms of which he can formulate specific new insights. Taking over the therapist's framework represents the only economical solution to this problem during the early stages of therapy. As therapy proceeds, however, and the patient manages to loosen his habitual ways of looking at things and to acquire new insights, he should no longer be dependent on the therapist as an ideological fountainhead. He should be able, at that point, to become more selective with respect to the therapist's standpoint, to accept it not as a total system but as a source of useful hypotheses. He would then modify the therapist's standpoint to suit his own value system; he would accept parts of it and reject others in the light of his own experiences and his attempts to maximize his own values.

Thus, the challenge confronting the therapist is to induce an identification that contains the seeds of its own dissolution. It seems to me that such an outcome is most probable if the emphasis is on encouraging the patient to adopt a certain *process* of looking at himself and the world, rather than a certain set of specific formulations. What should ideally remain from the patient's identification with the therapist is the process of self-examination, based originally on emulation of the therapist—a process that involves splitting his ego and observing his own behavior from the outside, the way the therapist would observe it. Adoption of the therapist's standpoint in that sense would enable the patient to carry on the therapeutic process outside of therapy, even after therapy has been terminated, and would mediate internalized changes as the patient examines his own behavior in specific real-life situations.

It is, of course, possible for the therapeutic relationship to become fixated at the level of identification. The patient may adopt the therapist's values as his own and build a whole philosophy of life on the therapist's standpoint (or at least on his interpretation of the therapist's standpoint). Thus, for example, he may take over psychoanalysis as a total ideology, a way of life, a cause. There are some striking similarities between this type of ideological conversion and some of the effects observed in the "brainwashing" situation where the adoption of "the people's standpoint" and of Marxist ideology are induced (cf. Lifton, 1956; Frank, 1959). Needless to say, there are vast differences in the goals and procedures of the two situations, and ideological conversion in therapy stems largely from the needs

of the patient rather than the wishes of the therapist. Nevertheless, therapists can profit from studying the conditions under which brainwashing occurs and seeing in what parallel ways they may inadvertently be structuring the therapeutic situation so as to make ideological conversion a likely outcome. Generally, the changes produced under these circumstances will persist as long as the patient is able to maintain, in some way, the relationship to the therapist or some substitute for it: the patient may remain in therapy for a long time, or return to it repeatedly; or he may build a substitute into his daily life, for example, by establishing active ties with the mental health movement. As long as these relationships persist, they may lend stability to the patient's self-concept and represent a meaningful, if limited, form of improvement.

The group can contribute to this aspect of the therapeutic process by incorporating the therapist's standpoint—the new frame of reference for seeing one's self and one's interpersonal relationships, induced by the therapist—into its normative structure. To the extent that the patient uses the therapy group as a relevant "*normative*" reference group, he will be motivated to live up to its expectations, not only within the therapy situation but also outside of it, and, accordingly, to adopt the standpoint that the group supports. The likelihood that the patient will identify with the therapy group and that it will serve as an important reference group for him is quite high in view of the group's special contribution to his attainment of a more favorable self-definition, as discussed above. The more cohesive a group becomes, the more likely the patient is to adhere to its norms even in the absence of direct surveillance.

The primary value of the group in the present context, then, is that it can use its considerable power in support of the adoption of the therapist's standpoint. This support may make a great deal of difference, since the therapist's standpoint tends to fly in the face of the conventional norms prevalent in the patient's own social milieu (cf. Beck, 1958); despite strong identification with the therapist, the patient is usually subject to normative pressures to reject his deviant ideology. Under these circumstances, the availability of a reference group that supports and prescribes these norms, even though it is an atypical group as far as society at large is concerned, reduces the conflict engendered by the therapist's standpoint and provides the consensual validation necessary for its adoption. The assumption in all of this is, of course, that the group will develop norms in support of the therapist's standpoint rather than in opposition to it. The latter possibility cannot be completely dismissed, although it is not a likely development. While group members may occasionally support each other in their resistance to the therapist's influence (cf. Bennis, 1961), the group is not likely to develop this resistance into a definite, normatively prescribed standpoint

that opposes the therapist's standpoint. A therapy group of neurotic patients typically lacks the independent power to accomplish this. To induce a particular standpoint, the group would have to be cohesive, but, as Frank (1957, p. 61) points out, the therapy group "can develop cohesiveness only by incorporating the standards of the therapist." Nevertheless, it must be kept in mind that lack of support from the group (even in the absence of a normatively structured opposition) can reduce the therapist's effectiveness. The therapist must, therefore, encourage the group to incorporate his standpoint into its normative structure.

3. *Generalization of Therapeutic Insights to Specific Real-Life Situations*

The ultimate goal of psychotherapy is achieved when the patient generalizes therapeutic insights to specific situations in his daily life. He addresses himself to interpersonal situations in which he has problems, situations in which he is ineffective, self-defeating, and uncomfortable. He examines these situations from the point of view of his own contributions to them, the attitudes and expectations that he brings to them, the elements of distortion and unrealism with which he approaches them, and the kind of interaction patterns in which he typically becomes involved. In this examination, the patient applies the insights he derived from corrective emotional experiences in the therapy situation to the real-life situation with which he is now confronted.

The significance of this part of the process lies in the fact that insights are applied to *specific* situations. That is, the patient does not merely adopt some general formulation about himself and interpersonal relationships which he then carries with him into his real-life situations (which is the part of the process discussed in the preceding section). Rather, he goes a step beyond that and involves himself in a more active and idiosyncratic process, not just taking over and expounding an explanatory system and a language but deliberately applying them in a concrete and unique situation. If this application is to be meaningful, it must be based not merely on the general formulations that the patient has learned but on the specific personal insights that he has had in the course of his therapeutic experiences. Moreover, it must involve a consideration of the special characteristics of the life situation to which the insights are generalized. If the process takes this form, then it represents a continued testing and evaluation of the therapeutic learnings as they are applied to real-life experiences, and probably some modification in them in the light of new data. Any changes produced by this process are likely to be at the level of internalization: they should be independent of the patient's relationship to the therapist and integrated with his own value system.

As has already been mentioned, this is the type of process that should go on after therapy has been terminated; adoption of the process of self-examination is perhaps the most valuable carry-over from therapy to the patient's subsequent daily life. This process, however, begins while the patient is still in therapy. Typically, a corrective emotional experience within the therapy situation itself is followed by an attempt to apply the insights derived from this experience to some of the patient's troublesome relationships outside of therapy. That is, the patient is encouraged to examine some of his real-life relationships in the light of the new insight so that he can gain a better leverage on them. Experimentation with new behavior is often tied to this process. Thus, following a corrective emotional experience, the patient would be encouraged to generalize the insights derived from it to real-life situations and to plan new behavior accordingly. In subsequent therapy sessions, the patient's attempts to apply the new insights and to experiment with new behaviors can be brought back for further review. The generalization of therapeutic insights can be facilitated in the therapy situation itself by reviewing, particularly in the aftermath of a corrective emotional experience, both the patient's current behavior outside of therapy and his attempts at changing his behavior.

The therapist contributes to this part of the therapeutic process by taking the role of an *auxiliary reality tester*. As the patient examines his current behavior outside of therapy, the therapist can help him reality-test by calling attention to the points at which his perceptions and expectations of others are likely to be distorted and by making him aware of the reactions that his behavior is likely to generate in the people with whom he interacts. When the patient plans new behavior outside of therapy, in the light of his new insights, the therapist again can help him reality-test by anticipating the kinds of reactions that his behavior is likely to produce in others. Similarly, when the patient brings back to the therapy session reviews of his attempts at trying out new behavior patterns, the therapist can help in the interpretation of the effects that this behavior produced in others and in the explanation of the reasons for these effects. The therapist's usefulness as an auxiliary reality tester is based on his role of an objective outside observer who is generally wise, knowledgeable about human relations, and familiar with social reality and the prevailing cultural norms. Nevertheless, the therapist's contribution to this part of the process is limited. He can only speak about social reality, indirectly, on the basis of the patient's reports and of his own estimation of the social situations to which these reports refer.

In group therapy, the group is in a unique position to make a special contribution to this aspect of the therapeutic process. The group "is more like society in miniature" (Frank and Ascher, 1951, p. 127). It can facilitate

reality testing by bringing society, to a certain extent, directly into the therapy situation. Despite the fact that the group members are in some sense social deviates themselves, they are, in general, sufficiently close to the cultural norms to serve as adequate *representatives of society*. Thus, as the patient examines his current behavior outside of therapy, he can reality-test his interpretations immediately and directly by turning to his fellow-patients. They can inform him about their probable attitudes and reactions if they had been his partners in the situations about which he is reporting. To the extent that they come from a similar milieu and represent a wide range of social roles within it, they should be able to give him a reasonably accurate picture of the social reality that he faces. In fact, they are more likely to give him an accurate picture than he would obtain in real-life situations, since the therapy group operates in terms of the norm of honestly stating what is on one's mind.

When the patient entertains the possibility of trying out new behavior in the light of his new insights, the group can again be very useful by helping him anticipate the reactions that this behavior is likely to produce in the real world. As representatives of society, they can remind him of the social expectations that circumscribe this behavior; they can point out the unrealistic features of his expectations; and they can inform him whether he underestimates or overestimates the negative effects that the planned actions are likely to produce. The group situation provides the patient with the opportunity to engage in an anticipatory practice session, a dry run of the behavior that he will try out in real life. This allows him to reality-test the new behavior under conditions that are both realistic and protective: failure in this situation is not as devastating as it would be outside, since in the therapy group the patient does not "play for real" and he knows that he is in a supportive environment.

Finally, when the patient brings back to the group reports of his experimentation for subsequent examination, he can again benefit from the group's reaction. In the group situation, there is the opportunity for a fairly realistic re-enactment of the real-life experience that the patient has reported. The other group members can indicate directly how they would have reacted if they had been the other participants in the interaction. As a result, the patient can gain a fuller understanding of the adequacy of his expectations and of the social effects of his new behavior. He can see more clearly and dramatically where he has succeeded and where he has failed.

CONCLUSION

An analysis of the influence processes involved in group therapy has been presented, and their role in the production of therapeutically relevant

changes in the patient's behavior, both within the therapy situation and outside of it, has been described. The analysis was based on a theoretical framework for the study of social influence in general, which was applied here to the special circumstances of the therapy situation. My assumption throughout was that, even in group therapy, the therapist is and must be the primary influencing agent. I tried to point out, however, that there are a variety of very important, unique, and powerful contributions that the group can make to the production of therapeutic change. At the same time, one must remain aware of the possibility that, under certain circumstances, the group may impede or weaken the therapeutic process. It is up to the therapist to make sure that the potentials for therapeutic change that are inherent in the group are maximized and that its possible antitherapeutic effects are minimized. Moreover, the influence processes that characterize the group situation and the varying potentialities of the group have to be taken into account deliberately in the composition of the group and in the decision, for any given individual, as to whether group therapy is the indicated form of treatment.

The kind of systematic analysis that I have offered here may seem arbitrary in that it makes sharp distinctions between changes inside and outside the therapy situation and between different stages and the influence processes that are relevant to them. Needless to say, I do not assume that these neat separations are possible in the actual situation. They are made only for analytic purposes. I hope that they will prove useful by yielding certain implications for the practice of group therapy. It seems to me that this kind of approach may (1) point to some of the features of the group therapy situation that have to be manipulated in order to strengthen its potential for change; (2) help to locate those features that have potentially antitherapeutic effects; and (3) help to provide some criteria both for the selection of patients who can benefit from this experience and for the composition of therapy groups so as to maximize their ability to produce therapeutic changes.

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DISCUSSION

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I would like, first of all, to express my personal gratification at the convening of this panel and at the opportunity afforded me to participate in it. This symposium represents the much hoped-for recognition that the fields of group psychotherapy and of group dynamics both have relevance for the understanding of "what makes groups tick." Indeed, it goes considerably beyond this insofar as most of its participants have had the actual experience of collaborating in interdisciplinary tasks pertaining to group treatment or to group process training.

Dr. Kelman has presented to us a clear and comprehensive paper which views psychotherapy in general and group psychotherapy in particular as a learning process in which social influences are made to impinge on the individual patient. He identifies three basic influence processes—compliance, identification, and internalization—with specific roles for the therapist and the group in promoting therapeutic changes in patient behavior.

Viewing the material as a clinician, my general response is a positive one. To begin with, I am pleased that a social scientist chose to discuss therapy groups rather than the, to me, more distant and artificial college student or air force team type of groupings. Dr. Kelman's over-all model, that of motivational forces inherent in the relationship to the therapist and to the group members which exert a constructive "push" toward lasting change in patients, does not appear basically at odds with what I have been taught and what I have observed in clinic settings. In fact, the three influence processes suggest to me some new possibilities for ways of ascertaining how permanent and extensive are improvements in patient attitudes and relationships.

With this broad favorable orientation to Dr. Kelman's paper go some inevitable questions, however. I have a strong feeling that there is more to psychotherapy than Dr. Kelman has described. Despite his utilization of the concepts of "corrective emotional experience" and of transference, his model seems somewhat narrow and oversimplified. It appears to be directed primarily at the product, the end result, rather than at the complex process of therapy itself. Furthermore, his framework emphasizes the positive, overt, and rational aspects at the expense of the conflictual, irrational, and defensive aspects of the group treatment experience. It also shows an almost exclusive preoccupation with *insight* kinds of therapy and fails to

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give sufficient weight to the *experiential* and nonverbal aspects of treatment which hold particular promise for the most disturbed patients.

As for Dr. Kelman's theoretical constructs, I am impressed by the clarity and conciseness of his definitions. If clinicians could only follow his example and state their propositions operationally, the task of integrating individual and group psychological concepts would be greatly facilitated. In this connection, I wonder whether clinicians might more easily understand Dr. Kelman's three basic influence processes had he not utilized such terms as "identification" and "internalization." These two terms have been a part of Freudian theory with quite different connotations. *Internalization* has at times been used by analysts to refer to the end product or permanence of certain kinds of identification, while the concept of identification has at least eight different generic meanings noted in the literature (this number does not include Melanie Klein's more recent terms of "introjective" and "projective" identification) (Scheidlinger, 1960).

How has Dr. Kelman utilized this term? Since *identification* as an unconscious process is generally considered a basic explanatory concept in psychoanalytic group psychology, it might be of interest to consider this. To begin with, identification with the therapist is seen by Dr. Kelman as an immature and transitory relationship which helps to shape the patients' positive set to treatment. One aspect includes viewing the therapist as a role model, as someone to emulate. In a more specific sense there is the notion of "taking over the therapist's attitudes" toward the patient and toward the therapeutic situation, with a resulting enhanced self-esteem and sense of hopefulness. This kind of identification is equated by Dr. Kelman with Freud's idea of a basic positive transference in the treatment situation. Since identification and transference have been viewed by Freudians as basically different concepts, Dr. Kelman's terminology is likely to create misunderstanding. There is also brief mention of identification in the sense of empathy, of obtaining gratification vicariously. Dr. Kelman alludes to, but does not develop, the idea of a kind of dependent, submissive identification accruing from the patients' view of the therapist as an expert who inspires faith in his ability to help. This bears a similarity to the observation by some group therapists of a shared group identification in the earliest phases of treatment wherein the therapist is perceived as a magical and omnipotent authority figure. The only specific reference to identification as a *group-related* process occurs in connection with Dr. Kelman's listing of the general values of group versus individual treatment, where, in his view, the sense of shared problems and a common faith enhances the patients' "identification with the group."

It is noteworthy that most of Dr. Kelman's descriptions of the group processes per se refer to the observable, interpersonal level and that there

is a minimum of reference to the intrapsychic and "regressive" level. This focus on the conscious, overt level of group dynamics is exemplified in Dr. Kelman's discussion of group cohesiveness as a force influencing the patient's positive commitment to therapy. He fails to allow for an equally strong group cohesiveness on the subsurface, unconscious level, frequently operating in opposition to the reality-geared group therapeutic task. In this connection, we must note Dr. Kelman's basic assumption that "the therapist is and must be the primary influencing agent." While many group therapists share his view, others insist that the group is as primary in this respect as the therapist.

When Dr. Kelman deals with the patients' emotional expressions in the context of the "corrective emotional experience," he ascribes to these a "real-life level of emotional intensity." One could ask here whether these emotional expressions, encouraged as they are by the regressive forces at work in analytic therapy groups, do not occur quite frequently on a considerably "deeper" level of emotional intensity.

Dr. Kelman's three influence processes involve a hierarchy of steps leading to an optimum stage of emotional maturity in the patient, characterized by a flexible and independent rearrangement of his value system. In an extended sense this progression is not unlike the phases of group development outlined by a number of writers, among them Bennis and Shepard (1956) for training groups and more recently by Kaplan and Roman (1963) for therapy groups. There is one part in Dr. Kelman's exposition which I would like to commend particularly to the attention of clinicians. I am referring to his simultaneous stress on the individual patient's transference distortions together with the patient's perception of the therapist as a real person. He also emphasized the reality-geared aspects of the group, the interpersonal issues, norms, role functions—in brief, the group as a kind of "society in miniature." With it went his illuminating portrayal of the final aims of all insight therapy: the conscious utilization of self-examination, of a flexible process of viewing oneself and others and of the integration of old and new values. These propositions are not at variance with psychoanalytic theory. They have definite relevance for the all too frequently forgotten field of ego psychology. Such concepts as Anna Freud's "observing part of the ego," Hartmann's "conflict-free sphere of the ego," Kris' "regression in the service of the ego," reality testing and the synthetic ego functions, all refer to similar issues.

In conclusion, I should like to emphasize that Dr. Kelman's formulations are of definite value in furthering our understanding of group psychotherapy as one kind of group influence attempt aimed at promoting change and growth in individuals. It is my belief that his theoretical model of the therapeutic process could be broadened and thus be rendered even more

useful by the inclusion of some of the more "depth"-oriented psychoanalytic concepts of group behavior. Only through integration of the theories and experiences of both social scientists *and* group therapists will we see the full flowering of truly creative practice and research.

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It is quite fashionable, in these days of impending nuclear catastrophe, to refer to the disparity between the accelerating pace of man's technological achievements and the comparative lag in the social sciences. Although I am unwilling to designate anything less than the banishment of war as a major breakthrough, I am pleased to report my impressions of mild progress in the argument to which we address ourselves today.

The position papers presented by Drs. Kelman and Semrad seem to me to represent some advance in the level of discourse over a similar A.G.-P.A. Conference symposium reported in the January, 1957, issue of the *International Journal of Group Psychotherapy*.

In advance of any reading of the papers, I heard wild rumors and alarms that this entire panel was to be a big bust, full of unutterable confusion because those selected to present the position papers were either misguided or had not properly understood the instructions of the chairmen. It was even bruited about, if you can believe it, that it was proving difficult to distinguish the group dynamics presentation from that which purported to represent the field of group therapy. There seemed to be the uneasy suspicion that spies and saboteurs had penetrated each of the camps, that perhaps they had even been consorting with each other, and that all was lost unless we, the panelists, came to the rescue.

Now that I have read both papers quite carefully, I had best confess outright that if you, the audience, or those who have made the arrangements for the conduct of this war are counting on me to keep the fires of battle burning bright, I am going to be a disappointment to you.

It is true that, as a group therapist, I do experience somewhat more difficulty with Dr. Kelman's paper than in reading a paper of one of the group dynamicist's represented in the 1957 symposium. Telltale labels and give-away phrases are a little harder to spot, and Kelman, devilishly clever enemy that he is, seems (from some bootleg source, no doubt) to have acquired something more than a passing knowledge of the therapeutic process, both individual and group. For those to whom the latter idea is just

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too incredible, be consoled by the unreliability of the source from which it comes. Despite my more respectable background as a psychoanalyst and group psychotherapist, and even before exposure to the corrupting influence of Dr. Kelman's paper, I had fallen into something like the degraded point of view represented in Kelman's statement that, "Psychotherapy can be regarded as a social influence situation in which the patient's relationship to the therapist is the primary vehicle for the production of therapeutic change." Thus, I refuse to be shocked at the suggestion that, "While psychotherapy constitutes a very unique kind of interaction situation, it is nevertheless continuous with other social situations in which changes in behavior and personality are induced." But then what better can be expected of someone who, in one of his more provocative moods, has been known to refer to psychoanalysis as "that curious kind of group therapy conducted in a dyadic group."

I find myself quite at home with Kelman's attempt to delineate the antecedent conditions of compliance, identification, and internalization and to compare their behavioral impact in and out of both the individual and group therapy situations. As a matter of fact, like Dr. Semrad and other colleagues, I have, despite some reservations, been increasingly impressed by the substantial core of common elements in seemingly disparate situations involving human behavioral change. I am in complete agreement with Parsons and Bales (1955) that even such diverse processes as those involved in learning, psychotherapy, and the socialization of the child do have similar "crucial elements" which may be delineated in common terms if we are willing to concede that teacher, therapist, and parent may all address themselves to the task of producing in pupil, patient, and child changes in behavior which may involve substantial alterations in their mode of operation as well as in their conscious and unconscious perceptions of self, world, and other people. Within so broad a context as this, surely it is not surprising to find that certain similar conditions are necessary prerequisites to all three kinds of change: (1) whether the changer is a teacher, therapist, or parent, he must have a subject who is experiencing some degree of frustration; (2) the changer must control through some means the sources of gratification and frustration; and (3) there must be initially established some dependency or attachment on the part of the subject toward the person interested in bringing about change.

If one is at all inclined to think in such terms, agreement with these broad principles is easy. Life becomes a little more complicated, however, when one attempts the more precise distinctions required in Dr. Kelman's comparison of the types of influence involved in the production of change in the individual and group therapy situations.

Within the limitation of the time permitted for these remarks, I have selected a few points in Dr. Kelman's presentation with a view to pointing up some of the problems involved in the very useful but exceedingly difficult endeavor in which he is engaged. Although Dr. Kelman cautions us in his conclusion that the sharp distinctions he makes between different stages of the influence process "are made only for analytic purposes," I am sure that he can no more expect this warning to protect him or his model against all criticism than those manufacturers who defend themselves in advance by stamping on their products: "For the prevention of disease only." We know that Dr. Kelman does not assume that "these neat separations are possible in the actual situation." However, if he risks addressing himself to group therapists, he must expect us to test his model against our way of looking at, and dealing with, those clinical situations with which we are most familiar.

Kelman refers to the process of identification as one in which the person "is able to see himself as similar to the other or . . . enacting a role reciprocal to that of the other." Later on he states that, "The likelihood that the patient will identify with the therapy group and that it will serve as an important reference group for him is quite high . . ." and that, "The more cohesive a group becomes the more likely the patient is to adhere to its norms even in the absence of direct surveillance."

At first glance these statements seem to me, as a clinician, both a familiar way of approaching the matter and a reasonable approximation of what actually does often occur. Yet, on further reflection I find myself calling to mind numerous instances in which, as a *particular* group became more cohesive, the *less* some patients tended to adhere to its norms, especially in the absence of direct surveillance.

It would be fruitless to put Dr. Kelman's experience and my own to experimental test unless we can come to somewhat more precise and elaborate definitions of such concepts as cohesion and identification than may have been possible for Dr. Kelman within the confines of a single paper. Should we not, however, if we are to compare his experiences and mine specify whether the concept of "identification" as used in this instance refers (as both Kelman and Freud say it may) to identification with the therapist, a fellow group member, the group as a whole, or simply with an idea? Does Kelman include within his category of identification the possibility of "identification with the aggressor," in Anna Freud's sense, or identification with a central person as an object of hate, as described by Redl?

Kelman says that, "The more cohesive a group becomes, the more likely a patient is to adhere to its norms even in the absence of direct surveillance." Contrast this statement with Frank's (1957) observation that,

"Cohesiveness does not necessarily imply pressure toward conformity, which is undesirable in therapeutic groups, because the standards of even a cohesive group encourage diversity." In a similar vein, Slavson (1957) says, "Group cohesion has to be prevented so that each can communicate his problems and work them through. This requires freedom and the retention of one's own ego and super-ego functioning."

One last citation, from Dr. Kelman's colleagues at the University of Michigan, should be added to complete our confusion. Cartwright and Lippitt (1957) in the 1957 symposium cite Kelly and Shapiro (1954) to the effect that, "The more an individual feels accepted by the other members of the group, the more ready he should be to deviate from the beliefs of the majority under conditions where objectively correct deviation would be in the group's best interests." It is also stated that, "Those in a position of leadership are freer to deviate from group standards than those of lesser status," but that "just the opposite conclusion has been drawn by others." I do not cite these conflicting and contradictory reports because I wish to cast doubt on the model that Dr. Kelman has offered us but, rather, to demonstrate its limitations when we attempt to use it within the damnably complicated world of the clinician working with a therapy group.

However, it is precisely because the clinical situation is so complex that we must look to models fashioned in part within the simpler world of the laboratory group, provided we are cautious in our extrapolations and modest about our readiness to generalize.

I must admit that I would feel a bit more comfortable about addressing these grandfatherly admonitions to Dr. Kelman if we group therapists were ourselves better behaved in this regard. I wonder if, in our own writings, we have not given encouragement to what seems to be Dr. Kelman's implicit assumption that the conditions for the operation of compliance, identification, and internalization are similar in all kinds of therapy groups. There undoubtedly are enough common elements even among groups conducted in diverse settings, with differing compositions and goals and at various phases of development, to justify the construction of a scheme like Dr. Kelman's. However, I would like to suggest that the application of such a model must be qualified and extended by the kind of considerations which follow. To illustrate them, I have chosen to apply Kelman's model to quite diverse group therapy situations for the purpose of examining the kind of problems we as clinicians might anticipate in trying to fulfill the "hope" Dr. Kelman expressed in his conclusions that his model may be used "... to locate those features that have potentially antitherapeutic effects ... (and) help to provide some criteria ... for the selection of patients who can benefit from this experience. ..."

Let us examine for a moment the problem of inducing in a new patient

that sort of behavior which Kelman has described as "engagement in the therapeutic work" or "obeying the basic rule," which he says requires "almost invariably some degree of compliance at this stage of therapy." If it is a question of engaging in treatment a middle-class neurotic adult in private practice, that will be quite a different matter from engaging a lower-class adolescent with a character disorder in treatment in a court clinic. Most analytically trained therapists find it much easier initially to induce adult neurotics to obey the "basic rule" in individual rather than in group treatment. My own experience and that of others who have worked in court clinics is that the situation with the adolescent delinquent is precisely the reverse: it is very difficult to engage such youth in the therapeutic work in the individual treatment situation, much easier to do so in the therapy group. As a matter of fact, the question of whether to use individual or group treatment with adolescent delinquents is sometimes an academic one; if the therapist does not employ the group it may be impossible to initiate treatment at all simply because the youth will not come to the clinic. Here, it is undoubtedly the influence of the group inducing compliance, and one might well say that "changes in (his) behavior outside of therapy are tied strictly to the approval of the therapist or the group." However, Kelman's suggestion that such changes in behavior "will be limited" and will tend to persist only as long as direct surveillance by the therapist or the group continues is more applicable to the adult neurotic than to the youthful delinquent. Clearly, the process of being induced into the compliant behavior of engaging in therapeutic work will have a quite different meaning to the patient whose therapist may quite realistically be viewed as "the enemy" because his life has been one long series of cruel or hurtful encounters with authority.

We do not have to search only among the adolescent delinquents to find therapeutic situations with comparable elements. Clinical experience with cases in which the group has *seemed* essentially to influence the patient *within* the therapy situation through compliance suggests that one may nevertheless attain effects outside of the therapy situation which Kelman quite properly associates with internalization, namely, the "generalization of therapeutic insight to specific life situations."

I (1954) have reported elsewhere in detail on such experiences and I do not want to use this occasion to persuade the audience or Dr. Kelman that they occurred as I reported them. Rather, I am fascinated with the possibility of going back to such clinical material with Dr. Kelman's model in hand to see if what I saw as influence based largely on compliance may look differently through Dr. Kelman's instrument. Even a brief glance at Dr. Kelman's chart is helpful in suggesting the possibility to me that there

may have been more of the antecedent conditions present than I recognized for the group to induce both identification and internalization.

Thus, I am already grateful for Dr. Kelman's contribution of a model which looks as if it may well be applicable to the confusing world in which we clinicians live. To my clinical colleagues, however, I extend a word of caution. Precisely because we have such a great need for points of view which can help us arrange the sometimes overwhelming data with which we deal, we must be careful not to buy order at the price of oversimplification. That would only make life more complicated both for us and our patients.

JEROME D. FRANK, M.D.^a

Since Dr. Kelman's conceptual framework, approach, and vocabulary may be strange or uncongenial to many group psychotherapists, I should like to elaborate briefly on his paper's significance. First of all, it focusses sharply on psychotherapy as an influencing process, that is, as an effort to change the behavior, attitudes, and values of the patient. We cannot get away from the recognition that the psychotherapist does try to change his patients, not merely to create conditions that encourage them to change themselves, and it is important to face the implications of this fact squarely, as Dr. Kelman has done. Secondly, Dr. Kelman sticks strictly to behavior, attitudes, and values and does not allow himself to get entangled in the knotty issues concerning the biological underpinnings of behavior, as many theorists about psychotherapy feel they must do. It is true that genetic and hormonal, and even instinctual factors if you will, are important determinants of human behavior, but psychotherapy per se does not touch them; and therefore a theory of psychotherapy does well not to get involved with them. Thirdly, Dr. Kelman's formulation is elegantly parsimonious. It encompasses in a single simple but powerful conceptual framework a vast number of therapeutic phenomena involving the patient, the therapist, and the situation in which they interact. His types of influence: compliance, identification, and internalization, cover more ground than might appear at first glance. Many therapists might question how this scheme deals with personality growth, for example. I believe that the concept of internalization adequately covers this, because what we mean by personality growth is internalization of more mature attitudes and values than the patient had to begin with, leading to more mature behavior. Finally, Dr. Kelman's conceptualization of the influencing process is one of the few that has

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generated questions which have been put to experimental test, and it is only through controlled experimentation that we can hope to lead psychotherapy out of the wilderness of conflicting and inadequately grounded theories in which it is currently enmeshed.

The presentation is so well integrated and inclusive that it is hard to find flaws or loopholes in it. At first glance, one has the impression that Dr. Kelman has really covered every aspect of the therapeutic process. Fortunately for the purposes of this panel, however, he has not managed to achieve quite this. To promote discussion, I should like to expand a bit on an important aspect of therapy which he has barely grazed, and to mention another one that is very difficult to deal with conceptually but cannot be ignored. The first area is the therapeutic role of conflict in therapy groups, the second the role of processes that go on more or less out of awareness.

The potential therapeutic value of conflicts between members depends on certain group standards. The first is that, like everything else that transpires in therapy groups, conflicts between members are to be regarded not as fights that must end in victory for one protagonist and defeat for the other but as occasions for learning. This is made possible by the fact that conflicts in therapy groups are relatively safe. No matter how intense the battle, it ends at the end of the session when the members go their respective ways. Though it is often resumed at the next meeting, it has no direct consequences for the patient's life in between. This quality of safety enhances the ability of the protagonists to maintain a degree of flexibility and detachment that is often not possible in the conflicts of daily life.

The potentialities of group conflicts for producing attitude change are enhanced by two other group standards. One concerns the other group members. Bystanders at an ordinary fight either watch passively, egg the opponents on, or try to stop the fight without worrying about what the fight is about. None of these responses helps them or the antagonists to learn anything from the fray. In therapy groups, the group standard is that any conflict is the concern of the entire group. Conflicts are not to be prolonged unduly, or prematurely terminated. Instead, members not directly involved are expected to use the occasion to clarify their own ideas on the issues involved and to help the protagonists clarify theirs.

Finally, a powerful standard of therapy groups requires protagonists to keep communicating no matter how annoyed with each other they get.

These group standards tend to cause conflicts to have more constructive outcomes than those in daily life. In the latter the major reactions of protagonists are to break off communication or to attempt to win. Neither response has much therapeutic value. If communication ceases, neither antagonist can learn anything from the clash, and each is left with his mis-

conceptions of the other intact. If the conflict ends in clear-cut victory for one antagonist and defeat for the other, the former is reinforced in his attitudes and the latter is demoralized and becomes preoccupied with reinstating his defenses, so neither is apt to be modified.

Conflicts between persons in close, continuing relation to each other, such as family members, are apt to have still a third outcome. Mutual withdrawal is impossible, and clear-cut decisions are rarely achieved. Instead, as the conflict persists, it generalizes to ever-widening areas of the protagonists' lives, so previously neutral occasions become excuses for taking up the cudgels again. Each antagonist becomes more and more expert at finding the chinks in the other's armor and more and more preoccupied with defending his own position. So, family conflicts tend to degenerate into self-reinforcing sadomasochistic patterns that become increasingly resistant to resolution.

In therapy groups, in contrast, conflicts become major incentives for attitude change. Since the antagonists cannot break off relations, they are impelled to keep trying to resolve their differences, and continued involvement of the other group members militates against the conflict settling into a fixed pattern. At the same time, the safety of the group helps keep emotional tension at levels that enhance flexibility rather than impede it.

Occasionally a group conflict may be resolved through the defeat of one antagonist, who comes to accept the position of the other as superior to his own. This resolution probably only occurs when the group, or most of it, sides with the winner, so that the loser's recognition of the superiority of the other's point of view usually leads to his increased acceptance by the group. This helps cushion the blow to his self-esteem and makes him more able to accept the new point of view through identification or internalization.

More typically, conflicts in therapy groups end without clear-cut resolution. They die down not because the protagonists flee from each other or because one scores a victory but because it becomes apparent to all that nothing is to be gained by pursuing them further. They end, as it were, in agreements to disagree. But even these inconclusive outcomes are therapeutically useful. In the process of conflict, each opponent has learned more about his own attitudes and problems as the stimulus of the conflict has exposed them to view and to the scrutiny of the group; and each has gained self-confidence through increased insight and through discovering that he could stand up under the attacks of his opponent.

It is obvious that in conflicts, as in other group events, much goes on more or less out of awareness of the participants, and it is this aspect of therapy that I believe is especially slighted in Dr. Kelman's presentation.

Many changes in a patient's attitudes and behavior seem to transpire without either patient or therapist being able to put his finger on what happened. This is especially true of corrective emotional experiences, which I believe involve more than the opportunity to examine one's attitudes and behavior while one is still experiencing the relevant feelings, significant as this may be.

Similarly, it is a universal observation that in therapy groups the ostensible topics of discussion at times all seem to reflect the same underlying theme or issue, to which each member is reacting in the light of his own experience. Whitman and Stock (1958) have come closest to conceptualizing this phenomenon adequately in their theory of focal group conflict and group solutional conflicts as efforts to deal with them. Group themes strengthen group cohesiveness, stimulate potentially beneficial emotional reactions, and have other therapeutic functions as well. A very condensed account of a group meeting, the first after the leader's return from vacation, may serve as an illustration. A female member first asked him if he *really* enjoyed his vacation, then said she had gone to many parties on hers, and went on to tell about being upset by a male friend at a party who kept kidding her about how aggressive and outspoken she was with men—she didn't like to think of herself as having a perpetual glint in her eye. Later, another woman spoke of her uneasiness because she was getting more involved with a man—she feared being swallowed up in the relationship. At this point, another said she didn't care what her roommate thought when she went off on a weekend skiing trip with the roommate's boy friend, but later added that she felt sick and nauseated on her return home. Meanwhile, the most isolated male group member said, "Aren't we supposed to get involved with each other here?" but denied, in response to a question from the therapist, that he felt left out. Later, another man commented that this same man had greeted one of the women very warmly when they came in, but the woman had not responded in kind. Then the woman said that it upset her to think that the man cared for her, just as her boy friend's growing interest in her did. Finally, the first woman who spoke began to praise an absent male member, and another male expressed his anger because she preferred the absent one to him.⁴

If each patient were asked why he made his remarks, he would attribute them to his own conscious preoccupations of the moment. He would be very unlikely spontaneously to see their relationship to a group theme. Yet, an observer can scarcely avoid the conclusion that the underlying theme, which was not fully in the consciousness of any patient, at least partly determined the thoughts of all of them.

⁴ I wish to thank Dr. Robert Ward for this example.

Unfortunately, though probably everyone would agree that a significant group theme is operating, probably no two would agree on precisely how to formulate it. The presentation is, of course, too fragmentary to serve for this purpose, but I suspect that even a full transcript would permit alternative interpretations, such as fear of intimacy, guilt over actual or fantasied sexual activities, competition of the female patients for the group leader and jealousy of him in the men, and so on.

The inferential nature of unconscious processes in therapy poses a very refractory research problem, but this does not diminish their probable importance. So, in conclusion, I would ask Dr. Kelman how he would deal with therapeutic phenomena that go on more or less out of awareness, especially those that engage several group members simultaneously, such as group themes.

HERBERT C. KELMAN, Ph.D.

FURTHER COMMENTS

The discussions of my paper by Drs. Frank, Peck, and Scheidlinger suggest several additional points that I would like to present in order to clarify my position. First, I would like to state clearly something that I simply neglected to mention in the paper, although I have assumed it throughout: my analysis was intended to refer specifically to adult psychoneurotic patients. While I feel that the same general principles should be applicable to other types of patients as well, I certainly agree that the specific forms that therapeutic processes are likely to take with other groups (such as adolescent delinquents or highly disturbed patients) will be different from the ones that I have described.

There are three general points that have been raised in the discussions, in one way or another, on which I would like to comment: my treatment (or lack of treatment) of unconscious factors; the problem of oversimplification; and my use of the term identification.

1. *On the Unconscious*

I would like to go on record as a believer in the unconscious, as someone who considers some such concept as the unconscious essential to any reasonable theory of neurosis. If I were doing psychotherapy, for example, I would certainly rely on the concept of the unconscious for my understanding of the patient's behavior, and I would try to convey this in my interpretations to the patient. My paper, however, does not deal with the content of therapeutic interpretations, but with the therapeutic process itself.

Here, too, I certainly believe that unconscious factors are operative. Much of what I describe clearly involves unconscious factors, even though I do not go into detail in pointing this out. For example, when I speak of the patient's learning to give the therapist what he seems to want, or developing a positive attachment to the therapist, or using the therapist as a transference object, I am dealing with phenomena that are largely unconscious. Moreover, my conception of the three processes of influence is one that includes their operation at an unconscious level. It seems to me that this is very clear for the process of identification, somewhat less so for compliance, and least for internalization. I will admit that my description of the process of internalization has rationalist overtones which make it sound as if it were a completely deliberate and conscious process; this is due to the way in which this concept developed, but is not inherent in its definition.

In short, I do assume and fully agree that unconscious processes operate in the therapy situation. The reason I do not dwell on the unconscious in my paper is simply that it does not enter into my theoretical framework as a systematic variable. In other words, while it is part of my view of the world, it is not part of my theoretical scheme. I assume that the particular relationships that I postulate do not vary systematically as a function of whether they occur on a conscious or unconscious level. This does not mean that they are not different, but simply that the conscious-unconscious dimension does not yield different predictions *in terms of the variables used in this system*. This is partly due to my assumption that conscious and unconscious processes are continuous with each other and run into each other, and to my further assumption that the motivated unconscious processes of psychoanalytic theory are only a small part of the pervasive behavioral phenomena that go on outside of the person's awareness.

It may very well be that my theoretical strategy is wrong and that the introduction of the conscious-unconscious dimension as a systematic variable would add power to my theoretical scheme, i.e., would yield certain differential predictions. I would certainly be open to this kind of suggestion. This is, after all, the way in which theoretical schemes typically grow and develop: critics come along and point up additional distinctions that should be made because they yield differential predictions (or distinctions that need not have been made because they do not make any difference). I would very much welcome this kind of criticism, i.e., some suggestion as to where specifically the conscious-unconscious dimension might enter into the theoretical scheme and what differential predictions would follow from introducing this distinction. I see no *a priori* reason, however, for introducing the concept of the unconscious as a systematic variable. There are many concepts that some people consider relevant to the processes I discuss—such as Gestalt, or cognitive dissonance, or operant conditioning

—but that do not form a part of my theoretical scheme. In a theoretical approach one has to pick a certain limited number of concepts and try to see how far one can go with them. It would not be reasonable to criticize such a scheme for the failure to use other concepts stemming out of a different theoretical system. These other concepts become relevant only if it can be shown that their introduction yields further and more refined predictions.

2. On Oversimplification

All theory is, of course, an attempt to simplify, to order complex phenomena in terms of a limited set of variables. Among social psychologists, there seem to be two approaches to theory construction. One starts with the formulation of a general principle and then proceeds to demonstrate the applicability of this principle to a wide range of phenomena. The other starts with the analysis of a set of phenomena, taking their complexity fully into account, and then tries to order them in terms of a set of concepts that is as parsimonious as possible given the complexity of the situation. I subscribe to the second type of approach because I feel that the first tends to lead to oversimplification, i.e., to the development of propositions that are not adequate to encompass the phenomena since they are not based on a thorough analysis of them. I find it surprising and, in a way, amusing, therefore, that my approach might be regarded as an oversimplification.

Needless to say, any theoretical approach, particularly in an underdeveloped field like ours, is only an approximation, and it can be shown that there are certain phenomena that it cannot fully account for. A theory develops, essentially, through a process of successive approximation, as it is confronted with troublesome phenomena and is modified in order to take these into account. It seems to me that the fact that a theory, in its first statement, *does not* account for everything would not justify the charge of oversimplification. I would speak of oversimplification only if a theory, by its very approach to the phenomena, *cannot* take certain relationships into account. Thus, for example, I would be suspicious of any approach that says "psychotherapy is nothing but . . ." and tries to reduce it to some more general process, without considering it in its own terms.

I feel that my analysis is very far from this kind of oversimplification. I do not try to reduce the therapy situation to something else, but to start from the realities of the situation itself and to see whether these can be ordered in terms of a limited (though not anemic) set of concepts. Why, then, does this attempt still impress some readers as an oversimplification? I wonder whether this might be related not to the adequacy of the concepts for encompassing the relevant phenomena at their own level, but to

some general notion about the depth or superficiality of concepts. In other words, I have the impression that some readers may react to my scheme as *oversimplified by definition* simply because it does not focus on unconscious processes. But this, I would submit, is really quite irrelevant. The fact that a theoretical scheme deals with the unconscious, with things that are not directly observable, does not necessarily make it complex, nor does the reverse make it oversimplified. "Depth" in the psychoanalytic sense does not necessarily mean complexity! In fact, Freud's concept of the unconscious can be regarded as one of history's most brilliant oversimplifications. Much current work, such as the work of the psychoanalytic ego psychologists to which Dr. Scheidlinger refers, is precisely designed to correct for this oversimplification.

In my own paper there is also some implied criticism of Freud's conceptions on the grounds that they are, in some respects, based on oversimplifications. For example, Freud views transference as largely a matter of unconscious displacement, and my own position is that this is a somewhat oversimplified description of what happens. While the processes to which Freud points are certainly operative, one cannot ignore two other considerations. First, there is a considerable body of work on person perception that has been done since Freud's time which suggests strongly that the patient is reacting to certain cues about the therapist's personality and attitudes emitted by the therapist. The emission and interpretation of such cues is a regular process in interpersonal relationships, and the patient does have some basis for drawing conclusions about the therapist (which may or may not be right). Secondly, one cannot ignore the actual role of the therapist, both as socially defined and as he enacts it. To the extent that Freud's formulation ignores these factors, it can be regarded as an oversimplification. I have brought up this example mainly to underline the point that the simple-complex dimension is completely independent of the conscious-unconscious dimension. I would like to argue that my analysis is an attempt to deal with some complexities that the psychoanalytic approach to the therapy situation does not encompass, largely because it is not based on an analysis of the therapeutic relationship as a social interaction situation.

3. On Identification

My definition of the term identification definitely includes such phenomena as "identification with the aggressor." I did not dwell on it in the paper because I was concerned only with the therapeutic uses of identification and did not have the opportunity to explore the concept in all of its ramifications. I distinguish between two types of identification: classical

identification and reciprocal-role identification. In the former variety, the individual takes *over* the role of the influencing agent because he finds it, in some way, desirable for himself. He is motivated to be like or, in fact, to be the other. When I speak of the attractiveness of the influencing agent here, I do not mean that the influencing agent is likable but that he occupies a status or enacts a role that the individual desires for himself. Taking his role represents a way of vicariously sharing the desirable characteristics that he possesses or attaining the resources to which he has access. In the case of identification with the aggressor, taking his role would represent a vicarious attainment of his power and control. It should be pointed out that classical identification does not necessarily involve competition for *scarce* resources. That is, the role of the influencing agent may be desirable because he has access to scarce resources, in which case taking over his role would mean vicariously taking away these resources from him (as in the case of identification with the aggressor or identification with the father in the Oedipus situation). However, the role of the influencing agent may also be desirable because he has access to resources that are non-scarce, in which case taking over would not mean taking away (as in the case of identification with a professional role model). The therapist has access to some resources that are scarce, such as his special professional status, and some resources that are non-scarce, such as the use of the process of examining one's behavior. I would hypothesize that identification based on the desire for scarce resources is likely to remain fixated at that level, while identification based on the desire for non-scarce resources is likely to proceed to subsequent internalization.

Identification with a group typically combines elements of classical identification and reciprocal-role identification. I am definitely concerned with identification as a group-related process. I would regard many of the manifestations of group influence that reference group theory focuses on as involving the process of identification. I discuss these in my paper when I speak of the role of the therapy group as both a comparison reference group and a normative reference group for the patient. Similarly, I would regard group cohesiveness as being related to the ability of the group to induce identification processes in its members. In this connection, let me point out that I do not assume that a cohesive group is necessarily marked by a greater degree of over-all conformity. I would only assume that the more cohesive the group, the greater its *ability* to induce conformity. The over-all amount of conformity will, of course, depend on the extent to which this ability is used and the range of member behaviors to which it is applied. It may very well be, for example, that a more cohesive group will be in a position to apply conformity pressures to a narrower range of behaviors.

Finally, I would like to comment on the use of the term identification,

which has so many meanings, especially in the psychoanalytic literature. I do, of course, present definitions of the terms identification and internalization, so that it should be clear to the reader in what sense I use these terms. Nevertheless, I would agree that, if a term already has one specific and generally accepted meaning, it is confusing to use it in a rather different way, even if one does offer a clear definition for one's own use of the term. I would feel it would be inappropriate, for example, to give a completely different definition to the term superego (unless one related it strictly to the concept as used in psychoanalytic theory). But the terms identification and internalization certainly do not have that kind of status in psychoanalytic theory. First of all, both of these terms are and have been used by sociologists as well, and it can hardly be said that they are strictly psychoanalytic concepts. Moreover, internalization, as far as I know, has no conceptual status at all within psychoanalytic theory; it is used rarely and loosely, and really does not represent a part of the systematic psychoanalytic vocabulary. Identification, on the other hand, has so many different definitions that it is hard to speak of it as a specific concept within psychoanalytic theory. Under these circumstances, I would argue that a new definition of these concepts—which covers most of the phenomena that the various psychoanalytic and sociological definitions are intended to cover—contributes at least as much to clarification as it does to confusion.

I feel, then, quite justified in using the term identification with the special definition that I assign to it. The question still remains, however, whether from the point of view of communication it is *wise* to use this term, considering all the surplus meaning that it carries. There would seem to be two opposing considerations. On the one hand, the surplus meaning may lead the reader to think that I am referring to some other phenomena and thus to become confused because he has first to suppress what he thought was meant before he can understand what was meant in fact. From that point of view, of course, it would be better to use something like "process X-23" which presumably suggests nothing until it is defined. On the other hand, surplus meaning has a positive value because it quickly alerts the reader to the kinds of phenomena with which, after all, I intend to deal. If he is reminded of psychoanalytic and sociological uses of the term, he does not have my precise definition in mind, but he is definitely on the right track. He is likely to be with me and to know what I am talking about and what I am trying to explain. Thus, the advantages and disadvantages of this term from the point of view of communication have to be balanced against each other. I felt that the advantages outweigh the disadvantages because it is unlikely that readers would have a clear definition of identification in mind which they would have to unlearn in order to understand me. Rather, what they would have in mind is a general set of

phenomena, vaguely defined, which is precisely the set of phenomena to which I want to refer. Nevertheless, I will admit that I am not entirely happy about the use of the term identification (and to a lesser extent the term internalization), but so far I have not come up with suitable alternatives.

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THE FIELD OF GROUP PSYCHOTHERAPY¹

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In the study of group dynamics and its application to group psychotherapy, the broad framework of psychodynamic psychiatry (Gitelson, 1951) has proved useful, concerned as it is with the whole man, the person in his genetic, behavioral, interpersonal, and social aspects, as seen from the standpoint of psychoanalysis. In the study of psychotherapy groups, this framework calls for examining the many sources of data that are available, especially the perceptions, behaviors, feelings, and attitudes of persons as they interact and interrelate.

In this paper, we review some problems and concepts of group dynamics and group process, as seen from our clinical experience. The discussion is restricted to groups brought together by a leader for the purpose of collaborating in the pursuit of an agreed-upon goal. In the interaction of a group, we observe who is doing what to whom (person), when (time), where (place), how (style), and why (purpose). The major issues will be discussed under five major headings: (1) the goal, (2) the vicissitudes of presence and contact of persons with one another, (3) the persons, (4) the leader, (5) group processes.

THE GOAL

The goal of a therapy group is improvement in personal functioning via a broadening and strengthening experience and some exposure of infantile needs and their eventual reduction (Mann, 1962).

The learning groups we conduct help create conditions which allow members to be participant observers. The goal is to increase awareness of motivations of behavior in groups and to examine conscious and, in some measure, unconscious subjective feelings inherent in the process. Members study their relationship to one another both in their transference aspects as well as in the feedback derived from their interaction with one another (Semrad and Arsenian, 1951; Semrad et al., 1958).

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Early in a group, a major piece of work centers around efforts to define and establish the goal before the participants, as it sets the stage for the total group effort and individual activity (Spotnitz, 1960). In production groups and to a lesser extent in committee groups the goal may be achieved through specific jobs to be done: everyone cannot do the same job; specific requirements of time and place are inherent in the task and are generated between or imposed upon everyone in the group. In therapy groups there is more ambiguity about the goal, and it is useful for members not to get allocated or assigned to specific roles. Even so, group work is often informally split up into task elements, positions, or functions. The group becomes a synthesis of persons, roles, cultural products, systems of values, and activities. Without a charter or by-laws, members develop an informal system which operates by precedents and rules laid down by themselves (Papanek, 1958). The norms often take precedence over individual values, perceptions, or idiosyncratic modes of behavior.

Approach to the goal is influenced by the nature of leadership, the roles of members, the group's internal structure and activity. Work toward the goal makes demands on group members to which they accommodate or resist in varying degrees. There is gratification as well as discomfort in the process of becoming and being a group so that it requires extra effort to keep in focus the group goal. Termination of a group is associated with the usual responses to loss: denial, depression, incorporative and restitutive efforts. If the goal is mourned and transformed into a useful memory there is a release of investment and interest for the pursuit of a new experience.

In group therapy also the achievement of the goal brings with it separation. Continuation of contact after the group meeting, stemming from blocks to the working through of an increased feeling of mutual identity, needs to be carefully discussed, prior to termination. Where separation leaves unfinished business, sharing of the perspective, hopes, anticipations, and sadness is indicated. The group can take away from the experience a memory of a time and place where feeling, thought, behavior, and reality in some of their varieties were increasingly honestly faced, suffered, enjoyed, and digested to become a broadening and strengthening experience. One important terminal guidepost is the recognition by members that the group's own course of development and mores are not universal, and that other groups invite their sympathetic participation, hopefully at a level of competence higher than in their previous experience.

VICISSITUDES OF PRESENCE AND CONTACT

In the transition from a collection of individuals gathered together to a group of persons collaborating in a mutual task, many complex emo-

tional interactions are observed. These will be discussed in terms of manifest interaction patterns—cooperation, competition, and conformity. Underlying these interaction patterns are psychological processes such as suggestion, imitation, identification, contagion, and compulsion.

In using the term cooperation, we wish to emphasize the emotional activities inherent in the working of two or more persons to produce some common effect. While most such activities facilitate collaboration and promote a feeling of common purpose and direction, some tend to be less helpful and more divisive in effect, as banding against the leader.

In using the term competition, we wish to focus again on the emotional aspects inherent in striving of two or more persons for the same object. In our groups, competitive actions may have the contrasting effects of making the group more cohesive yet rivalrous or divided into factions. Some competitive activities promote group formation, while others are pitted against it.

Conformity refers to behaviors or attitudes that are regulated in group behavior through norms, prescribed roles, and consensus of the members. Manifestations of conformity range from defensive self-assertion tending toward disunity to unconscious compliance tending toward unity. Conformity in word, gesture, posture, attitude, feelings often carries a quality of positive mutual feeling usually reserved for libidinal expression. Bion (1961), too, stresses Freud's hypothesis of libidinal ties for the "pairing" types of group activity. Viewed in the perspective of goal achievement, forces for conformity resist and/or channel competitive activities, transforming them into cooperation.

Cooperation, competition, and conformity as complex emotional activities vary at different levels and phases of group development. Each new group incident produces realignments in these interactions. Some have more impact than others. Some set the group back. The group repeatedly lives through threats of disintegration by trauma, frustration, jealousy, affection, anger, and loss. Mastery, or simply endurance of the common experience, tends toward cohesiveness and movement toward the goal.

From observation and testimony it is evident that the persons participate in a deeply emotional experience in their presence and contact with the leader and members of the group. To some extent individuality is surrendered as members venture into new relationships with others. In some cases, individual ego capacities for relationship can be enriched or altered. Within the group, alteration of ego boundaries produces increased anxiety, which fosters both regressive dependency and counteractive aggression. The observation and acceptance of both dependent and counterdependent attitudes as natural under the circumstances make it

possible for all members to continue their participation with a feeling of comfort and security.

Under conditions of stress within the capacity of the group to endure, there is growth and development in the group. Where stress goes beyond the sum total of supports from the individual personalities, group morale, environmental support, and effective leadership, the interactions and relationships take on a more disruptive, primitive, or disorganized character.

In our experience, groups seem to follow an endogenously unfolding program. The personality of the leader, those of the members and the group atmosphere and interactions modulate the pace of developments. Loss and frustration especially are observed to occasion reversion to withdrawal and group instability (Kaplan and Roman, 1961). The impact of a crisis varies depending on when it occurs in the group's history. A later trial may find the group holding to more mature attitudes and behaviors previously achieved.

THE PERSONS

Groups differ from one another in how their members meet the issues of presence and contact, and within any one group these processes are always in flux. Moreover, any individual member's behavior as a result of this evolvment is not always consistent with his biography as it is known. (See Scheidlinger, 1952, 1955, 1960.)

The effects of persons themselves on cooperation, competition, and conformity manifest first as personality variables which modify presence and contact according to the anxiety experienced by a given person in a group setting. These variables refer to individual personalities with their genetic and dynamic properties, their motivational and defensive patterns, conscious and unconscious. We will describe aspects of these personality variables first and then relate them to group behavior.

The more infantile the person, the more he fears his instincts. He brings to the complex emotional activities of group formation defenses against his instincts, motivated by a dread of the outside world. "... the ego does not defend itself only against the 'pain' arising from within. ... it experiences also 'pain' which has its source in the outside world. ... The greater importance of the outside world as a source of pleasure, and interest, the more opportunity is there to experience 'pain' from that quarter ... the ego ... endeavours in all kinds of ways to defend itself against the objective 'pain' and dangers which menace it." (Freud, A., 1946, p. 74.)

The infantile personality necessitates to a greater degree the presence of objects for sustainment, support, and gratification. By the same token, the infantile personality is more vulnerable to loss, frustration of object

need, and failure to remain held in a state of affection. We understand these manifestations of behavior in our groups to be similar to those observed in normal children and similarly related to early object anxiety as it has affected the capacity to postpone action by the use of repression and necessitated resort to flight to enable the person to survive. Persons in fleeing contrive to be pursued by others, in the pattern described by Winnicott (1955), that is, they move in such a way as to get again a good mother surrogate, and so perhaps achieve a degree of personal integration.

The effects of personality variables in a group can be related to the development of basic assumptions (Bion, 1961) which represent emotional states that have a central theme and relate to a group's aims. Basic assumptions are seen by Bion as defensive against psychotic anxiety and by us as defensive against object anxiety. The leader operates for purposes of sustaining, feeding, and protecting (dependent assumption), for supporting (fight-flight assumption, usually leader-associated), and for gratifying (assumption of pairing). Bion believes these assumptions are anchored in man's innermost core as a group animal. We incline to view them as manifestations of basic personality needs for objects manifesting at varying levels of ego development and functioning, and only highlighted in the group setting by presence and contact with persons and the object anxiety therein.

The more socialized the person, the more he deals with his instincts by defenses motivated by anxieties of conscience. In terms of the distribution of a person's defensive organization, it is useful to keep in mind that the defense mechanisms described by Anna Freud (1946) are more operative in the infantile personality, while the defenses described by Sigmund Freud (1921) are more operative against the instincts. In mature functioning, instincts are expressed and channeled by influences from the ego ideal and interests in creative pursuits.

Thus, manifestations of personality observed in group therapy can be presented in sequence from the infantile to the more mature; they include a range of behaviors which center around dependence and expectation of support as well as toleration from others (Beukenkamp, 1955; Kanter et al., 1963). Manifestly immature is petulance when the person's wishes are not immediately gratified. Some walk out or do not attend or speak of not getting anything, of being rejected, not loved, or persecuted.

The person's capacity to recognize and critically test the reality of others at such close range in the group may give way to denying the relevance of the other persons' presence as a source of discomfort and pain. For some the "painful" facts are canceled by an escape into fantasy ena-

bling the person to remain in the group presence, though ineffectively. Denial in fantasy can be kept to oneself and seldom intrudes into the group material.

More mature concerns center around attitudes and feelings about sharing and assuming responsibilities. The developmental struggle of the group in attaining its goal is articulated by individuals as spokesmen for the group. In matters of responsibility and work there is put forth the expectation that excuses and professions of ignorance will be accepted in place of responsible action. Members may band together against work by promoting an illusion that the profession of trust in the leader is an acceptable goal. Testing this passively, they surrender to him and overestimate him as a great or gifted leader. Alternately they may aggressively band against the leader, finding a spokesman to devalue him as an authority.

In addition to day-dreaming as a defense, there are denials in word and act, often of an infantile nature. Denial in word and act depends for its effectiveness on whether group members fall in with the dramatization. The indulgent permissiveness of the leader and mutual protective measures of fellow members determine the fate of the "pain" and the retention of unimpaired perception of reality. These behaviors are illustrative of limited cooperation.

Next in sequence, although frequently concomitant with dependency attitudes and feelings, come behavioral efforts at aggressive mastery and power-seeking. (See Lippitt et al., 1952.) In some instances these efforts are counterdependent. In other instances they show good leadership qualities. Members bring forth issues of being independent of the leader, decry hero-worshipping, promote organized activity against him, occasionally in an explosively destructive fashion with rivalry and self-consciousness. As with contagion in mass psychology, everything tends to be pushed to extremes, more in word than in act, however, in the service of forcing the leader to set limits.

Group members avoid encounter with the dangers felt in the situation by flight from or avoidance of the issues of "pain." The membership may be intimidated, inactive, disinclined, reluctant to commit themselves to any place in the group, contenting themselves with looking on as others work. The idling may have a destructive effect, for being bored leads to quarrels with those absorbed in work. These competitive behaviors, as resistances to cooperation, differ from neurotic inhibitions in that the spectator role may be abandoned, with change of anxiety level in the group.

Attitudes and feelings are disguised or shown in poses of sophistication, tendencies to extreme idealism, cynicism, idealization of aggressive competition, and easy frustration of personal independence. These be-

haviors are essentially restrictions rather than denials. Whereas denials are regularly attributed and associated with anxiety about other persons, the qualities of restriction are associated with inner dangers.

For all members the surrender of one's freedom of movement and the challenge to one's customary style of self-assertion produce a shared frustration under conditions of heightened self-awareness. The evidence of being in the same predicament of sharing and living through the same anxiety-provoking situations with very similar feelings enables each member to identify positively with every other member and so facilitates sympathy, mutual aid, and mutual imitation. This positive aspect of group identification corresponds to Freud's discussion of the army and the church in which members are united positively by identification with the leader and with each other—ego-ideal identification.

In those instances in which identification is combined with the mechanism of impersonating or identifying with the aggressor, group pressures in the presence of the leader come into focus. The leader represents the work function which is rooted in the reality principle, defined in this context as acknowledging, bearing, and putting into perspective feelings, attitudes, and behaviors. Through identification with the aggressor, members may take the leader's as well as other members' attitudes, characteristics, and opinions as their own. These, mutually shared, provide a limiting group code as a protective envelope for effective group functioning. In some measure these assimilations may be viewed as competitive. In their conforming aspects they aid persons to adapt more readily to external conditions.

The most mature behaviors, attitudes, and feelings observed are those of interdependence. They are characterized by less competitive striving, a reconciliation with the practical realities of interdependence, and greater acceptance of limitations upon oneself and others. Bach (1957) described these as "set up operations" which free and make available the inherent potentials for mutual aid and self-help in a group.

One type of interdependence seems aptly described as altruistic surrender (A. Freud, 1946). Members take a genuine interest in the gratification of other people's needs and indirectly gratify their own. One finds at times the liberation of inhibited activity or aggression primarily designed to secure fulfillment of an individual's own instinctual wishes utilized for a common or mutual need. As in the process of identification with the aggressor, passivity is transformed into activity, narcissistic surrender is compensated for by the sense of power associated with the role of benefactor, and passive toleration of frustration finds compensation in contributing happiness and helpfulness to others.

The effect of persons themselves on cooperation, competition, and

conformity as vicissitudes of presence and contact leaves unanswered several questions:

1. Is the clinical participant-observer alert and astute enough to differentiate and correctly identify a member's motivation for and group purpose of the defensive operations observed? Most clinicians find denial and repression easy to differentiate. The message from an individual member which indicates that he is being overwhelmed and asking for sustenance by denial is easily inferred. There is much more difficulty in differentiating defensive devices in clinical manifestation, which we may call restriction of ego, from inhibition.

2. Does identification which makes for possible characterologic change take place in the group mostly on an aggressive basis? Is identification with the aggressor not only a defense but also a step in development (Mann, 1962)? What are the specific contributions of a peer group to identification? Ego-ideal identifications are not always easy to differentiate from identifications with the aggressor, especially if this defensive position is shared by a pair of members. It is not easy to discern whether projection is in the service of object anxiety, superego anxiety, instinct anxiety, and/or ego anxiety. The person functioning as a person in a group, participating fully in the group's work, evidences anxiety with readiness, but inference of its source may be problematical even to the most experienced therapist, primarily because of the limitations imposed by the group on free association data.

In the answers to some of these questions there is possibly the clue to the differences (Berne, 1955, 1960; Kraft, 1960; Wolf et al., 1952; Burrow, 1928; Schwartz and Wolf, 1960) that have come up in the literature on "group analysis" as such, wherein the instrument of free association, so necessary to achieve such data, is limited in its application and limits fuller understanding of the meaning of behavior. Clarity about transferences as distinct from identifications, object ties, projective identifications, identifications especially among group members, or with the group as an entity, is especially difficult to maintain, since the issues of emotional nature, be they for sustenance, support, or gratification, are not consistently delineated by any one member, group of members, or the entire group at various phases of group development.

3. To what extent can the instrument of free association obtain and allow assessment of individual genetic and dynamic personality elements in their contribution to group processes? There are many limitations in group therapy as practiced which militate against more precise study of group dynamics with clinical tools: (a) The opportunity to make transference interpretations without an adequate opportunity for systematic working through; (b) The laying bare of a psychic mechanism of primary

process without an opportunity for a systematic analysis of its history and function; (c) The demonstration of resistance without an opportunity for systematic study of its origin and evolution; (d) The occurrence of a structural change without an opportunity for systematic study of its meaning; (e) The lapse into free association without an opportunity to pursue its course systematically without interruption.

The materials of group psychotherapy are more directly interactional and less fully verbal than in individual psychotherapy; thus, systematic studies require more dependence on the blending of the nonverbal communications with the verbal ones in group therapy. Anna Freud has pointed out that acting out may be no less difficult to analyze than verbal communication; it may be the therapist's smaller amount of experience with the former or anxiety about dealing with it that has led to a preference for analysis of verbal content.

Group interaction provides the person with an opportunity more fully to appreciate object anxiety (A. Freud, 1946) and the group members' growing experience with its management. Repeated effort of members to establish an equitable distance of affective operational relationship comes under observation especially in the crises occasioned by group participation. Not only does a member struggle with his object representations within, but also with objects without: his fellow members.

THE LEADER

Toward making a group experience constructive the leader invites members to acknowledge their feelings, tolerate anxiety, and work for perspective in understanding the process of being with and interacting with their fellow human beings. Through his functions as sustainer, supporter, and gratifier the leader aids members to contain anxiety in the service of goal achievement or work, in training groups for learning, and in therapy groups for experiencing a corrective (ego) personal experience (A. Freud, 1951). The leader contributes to the interactions by drawing on to himself and absorbing the aggression that is intolerable to members. This is not in the interest of self-sacrifice or self-gratification but to allow the group to do its work.

The leader's task is, initially, one of performing ego functions missing from the participation of the other group members. This requires attention to the group as a whole, to the comfort of individual persons, and to their development of understanding through the group experience.

In a therapeutic group, the aim of the group leader is to so conduct himself that the group members become increasingly independent of him.

To the extent that the leader remains central, the group may remain authoritarian and narcissistically oriented. To the extent that the group becomes peer-oriented, the leader may assume a position around the circle of the group, promoting interaction toward the group goal especially at those times when group members lose track of it.

The group therapist uses the setting, feelings, and interactions that emerge for crystallizing material which may benefit the group as a whole or give particular members things to reflect upon or react to. At times, the benefits of the whole group and the benefits of individuals are in the same direction; at times they are in conflict. This sometimes poses a difficult choice where attention to an individual may neglect the welfare of the entire group or where focus on the group may increase an individual's discomfort.

The analysis of the leader as a scapegoat is the most important neutralizing factor in the group situation. By accepting verbal attack and keeping the work to be done before the group, the leader promotes a situation in which the goal becomes an object substitute for the discharge of aggressive energy. The members by challenging and attacking the goal concomitantly create something which they understand because the leader is inviting them to test reality and formulate their experiences. By trading on the group's dissatisfactions with things as they are, the leader allows the group to postulate how things or themselves can be changed on the basis of reasonable planning and work.

Not to be overlooked is the function of the group for each individual as a here-and-now replica of society, representing the processes of socialization, reality perception and testing, and social modulation of intense affect or behavior. The group learns to recognize that different modes of operation have adaptive, dynamic, and genetic aspects, evident with increasing acceptance of free associations as the group engages the therapeutic tasks. These exert pressure for honesty, interpersonal relatedness, perspective, work, knowledge, and the bearing of healthy tension.

As members provoke and are provoked to dissatisfactions of which they become aware, the rivalry and competitiveness for the special attention and affection of the leader diminish to the extent that the members become more aware of each other as separate individuals with certain assets and liabilities which permit feelings of respect and of warmth if not of love. In large part the identification with the leader on an aggressive basis has been replaced by a more mature and useful identification with those aspects of the leader which stand for a helpful, understanding, impartial, respectful person. Upon separation each person carries these identifications into his own group or manifests them in the current group at an interdependent level.

GROUP PROCESS

Observations of presence and contact that appear more group-specific are determined by the group interactions themselves. They need careful consideration because they often occasion special problems to a group therapist whose primary orientation is toward individual therapy. In group interaction, members report and are observed to think, feel, and act differently from the manner in which they would or do in the more isolated contexts (Shapiro et al., 1959). Group dynamic elements such as climate, goals, structure, or code which emerge as the product of the interaction within the group, be it at conscious or unconscious levels, are to be observed. These are group-determined phenomena which emerge in the course of development with new properties not contained in miniature in the aggregate nor in an earlier stage of a person's life history and thus present a new dimension to consider, perhaps an organizer factor inherent in group functioning which as yet is not too clearly understood, at least by us. We do not suggest that persons always or necessarily lose their individuality in a group. Some part of the person is entered in the group complex, and some part of the person may be kept out. There seems to be an ebb and flow of investment and involvement of members. At times members are so absorbed as to lose their distinctiveness or individuality. Bion links this to "psychotic depersonalization." We think of it as a more normal process of assimilation in a group in which libidinal ties enhance cohesiveness and promote individual de-differentiation. At times members are so absorbed as to act out an ego-alien billet determined in large part by unawareness of compliance (Redl, 1942). At other times narcissism is so stimulated as to provoke self-assertion and withdrawal.

Consistent with Durkheim's observation on the central importance of a division of labor in group life, the groups we have observed show that from sustained presence and communication there regularly emerged a division of function. The functioning components we called "billets," a variant of the more familiar concept of "role" (Benne and Sheats, 1948). We proposed the new term because the unit of action and process appeared not always carried by an individual but often by a pair or larger cluster, and, more importantly, we want to convey the idea of a group-determined function (Shapiro et al., 1959).

Observing the complex emotional exchanges that take place beneath the mantle of goal-directed discussion, at a descriptive level we speak of competition, cooperation, and conformity. At another level the dynamic business of the group is expressed as varied billets subsumed under three functions, which we called "integral functions" (Arsenian et al., 1962). By

integral functions we mean to label the essential forces moving for *cohesion, dispersion, and ambivalence*.

The network of interpersonal relationships in time can be described from the point of view of individual psychology in terms of multiple transferences. It can also be described from the viewpoint of group psychology in terms of integral functions. The cohesive function, as the term suggests, is conceived as basic to likings, sympathies, mutual attractions, feelings of friendliness and belonging—as in an extended family. Dynamically we see in these more or less aim-inhibited expressions of libido, transference, and identifications—as when the group members use terms that are theirs alone, or when members take on each others' expressive and stylistic coloring or that of the leader-member.

The dispersive or divisive forces range from slight antipathies to major jealousies, including aggression and hatred, defensive identifications, and negative transference. It is our impression in both therapy and didactic groups that these forces subserving the integral function of dispersion are more conspicuous and perhaps stronger than those prompting union or cohesion. Hence the necessity for some patterning of the forces toward dispersion such that their energy is discharged without breaking the envelope of the group.

About the ambivalence function and its associated billets, these are in the service of suspension or delay and sometimes the energy involved may be used for goal pursuit or work. They function to postpone definite action, keep issues open, suspend movement by neutralizing group surges toward either cohesion or dispersion, alternating between freeing and immobilizing members. This affords an opportunity for the leader to channel their energy toward the group goal. Thus, we see our groups as tenuously equilibrated on the basis of the three integral functions. For each function there is a range of roles and billets. These billets manifest variously along several dimensions. There may be variation in number of persons, amount and range of affect inherent in them, amount and range of catharsis, discharge, or suspension linked with them, variation in degree of clarity and disguise of their underlying function, variation in social stimulus value, popularity, covertness, merit or demerit, variations in fixity to persons, group steadiness and constancy.

Although there are times when behaviors tend to satisfy individual needs, once a group has developed most group actions and group feelings are primarily group-oriented and group-determined, though mixtures are observed. Bach (1957) has also noted that, besides transference, counter-transference, and resistances, there are group situational concepts, such as cohesion, group moods, group roles, group pressures, and group tensions.

These group-specific data allow us to appreciate the necessity for some aim inhibition of both cohesive and divisive forces, whether these be construed as primary instincts, derivatives of other needs—perhaps in the service of the dependency-hostility series. We have hypothesized that groups must be able to express, pattern, or discharge cohesive and divisive tendencies in order to retain their integrity. Because suspension and delay of discharge of tension is consistently observed, we have postulated ambivalence as a third integral function, along with cohesion and dispersion. The uncommitted mass may provide basic energy either for goal pursuit and work or for sustained inertia.

SUMMARY

In summary, we have presented some of the dynamic processes of interaction in therapy and in training groups reviewed from clinical observations of groups of persons brought together by a leader in common pursuit of an agreed-upon goal. Presence and contact, and the developing perceptions, reactions, and incidents inherent in their vicissitudes, set a process in motion which runs its course. We have tried to present our understanding of some of the forces inherent in the therapeutic and learning process and, finally, some speculations on integral functions in groups.

Many questions remain which open invitations to direct controlled observation of groups conducted by therapists and by group dynamicists. Much work is yet to be accomplished to fulfill our need for theories and for their translation into operational terms and systematic study.

DISCUSSION

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I should mention at the outset two sources of difficulty (or resistance?) in commenting on Dr. Semrad's and his colleagues' paper in this restricted space. One of the problems has to do with the expanse, the range, the number of concepts and subtle shadings and the omnibus nature of the theory. There were times when, wistfully, I hoped I could say:

There are more things in heaven and earth, Horatio
Than are dreamt of in your philosophy.

But alas, I could not dream of any.

But as I reflected on the various uses of theory, the paper came into better perspective for me. A good theory can serve a number of purposes: (1) a *selective function* or "focus of convenience" which the theory under-

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lines by isolating those few factors which account for the salient effects; (2) a *heuristic function*, whereby theory is used to show relationships and generate simple research hypotheses; and (3) an illuminative function that lifts up and throws a searchlight on a broad array of interdependent factors.⁷ It is this last function which this paper serves so well and which remains at odds with the turgid rigor and spartan outcomes of most papers I'm accustomed to read and forget.

The second problem is more profound and more difficult for a social scientist to overcome. It has to do with a vision of reality and depth of experience which the authors bring to us. There is no question in my mind but that the words they use convey life as it is really lived in these groups, with all of its rich complexity and its primitive drama of existence. But like the search for truth which never reaches its goal yet never can be abandoned, the endeavor to articulate an experience can never succeed completely. "The lag, the discrepancy between experience and word is a productive force in man," Schachtel (1949) points out, "as long as he remains aware of it." The authors' awareness and struggle in narrowing the gap between experience and words makes reading this paper difficult and my own comments capable of either distorting their words to my experience or their experience to my words. The reality of the social scientist is more abstract and "sanitary," more controlled and determined, more inclined to use "the 50 minute group" than the reality which Dr. Semrad and his colleagues write of.⁸ I have tried to overcome this hurdle by remembering a tiny sliver of dialogue from a Christopher Fry play in which Aaron says to Moses: "Stay with reality," and Moses responds: "If I can penetrate that far!" Let us try.

For the remainder of this paper I will focus on only one aspect of the paper, that dealing with the nature of identification and the learning (or change or influence) processes in the groups the authors write of. Most of us who have attempted to understand the concept of identification are aware of the richness and complexity as well as the protean and elastic quality of this concept. Its power plus its amorphousness serves us so well that we tend to stretch it to include more and more instances of behavior and experience. Even in this symposium, we see that Kelman tends to use it in a way which stresses its positive affect, while Semrad emphasizes "identification with the aggressor."⁹

⁷ I am indebted to Jack Gibb's discussion on the uses of theory in his forthcoming paper, "Theory of the T-Group," in *Theories of T-Group Training*, edited by L. Bradford, K. D. Benne, J. Gibb, Wiley, in press for 1963.

⁸ For an elaboration of this point, see my paper "A Critique of Group Therapy Research," *This Journal*, 10:63-77, 1960.

⁹ Please do not misunderstand. I am talking about a matter of emphasis. Both Kelman and Semrad include both defensive and nondefensive identification in their theories, but their preferences are unmistakable.

detail the precise operations and behavior of the therapist in order to understand his effects.

To summarize, I have identified one of the many interesting propositions from the paper, that dealing with the influence or learning process as a result of identification with the aggressor. I have tried to augment the theory, not by questioning the importance of the identification-with-the-aggressor concept, but by exploring the possibility of other forms of identification. Perhaps these other forms of identification do not bring reality closer as forcibly as the aggressive type. This remains to be seen. Emerson seems to echo Semrad when he asks: "What is it we heartily wish of each other? Is it to be pleased and flattered? No, but to be convicted and exposed, to be shamed out of our nonsense of all kinds, and made men of, instead of ghosts and phantoms. We are weary of gliding ghost-like through the world, which is itself so slight and unreal. We crave a sense of reality, though it comes in strokes of pain."

HUBERT S. COFFEY, Ph.D.¹¹

This paper by Dr. Semrad and his co-authors is a rich mine of material concerning the interpersonal relations involved in a quasi-therapy group. It brings to attention a great variety of the issues which must be attended to in the understanding of what goes on in a therapy group. The very comprehensiveness of the approach and the felicity of expression are impressive. The communication of these issues in a style which incorporates feelings as well as abstractions is itself an accomplishment. While one finds this an extremely satisfying paper to read or to listen to, the very comprehensiveness of it poses problems in relation to the focal point of this symposium: the relationship of group therapy and group dynamics. How can we develop some set of hypotheses from such a paper which are amenable to scientific verification? And how should we go about trying to accomplish such a goal if that is what we want to do?

I have assumed that one of the major areas of conflict between those who have been identified with group therapy and those who have been identified with group dynamics centers around the nature of the process of verification which is involved in both fields. Since I am interested in both fields, I find myself caught in the middle, and there is no little ambivalence involved in my feelings about the arguments on both sides. I conceive of the "sides" really to be the reliance on different types of theory building and attention to different types of data. Semrad and his co-workers' paper is certainly abundant with many plausible insights about the nature of social interactions and the intrapsychic problems which are concomitant

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with those interactions, the relation between the outer manifestation and the inner event, the relation between the communicated intention and the therapeutic interpretation. Yet if one were to attempt to follow the principles of inquiry which have been developed around the concept of "social science," most of the observations and postulates would resist empirical test.

On the other hand, attempts to quantify in an empirical way the hypotheses which have direct relevance to the conduct of therapy have not always met with unqualified success. Social psychologists have been interested in the small group during the past two decades to a degree which is unprecedented in previous times. Studies of deviancy, conformity, cohesion, decision-making and a number of other aspects of groups have been undertaken by many investigators. Certainly many of the studies, while interesting in themselves, seem to have little pertinence for the actual conduct of groups, little application beyond the particular circumstance of the laboratory in which they were created.

Again, one should recognize that many of the empirical studies have drawn upon the theoretical formulations which have come from clinical observations, where the data for such formulations are almost entirely the product of the insightful perceptiveness of the participant observer. Certainly Semrad et al.'s paper is a compendium of such formulations, stemming, as they do, from psychoanalytic theory and enriched by the application of such understandings to the context of the small group. After all, it is difficult to think what social psychology would be if it had not profited by the insights and even by the errors of Freud.

The area to which I wish Dr. Semrad and his fellow workers might have given more attention is the cognitive area. Certainly one of the more vulnerable aspects of Freudian theory has been its neglect of the cognitive dimension involved in social roles, cultural norms, and the internalization of these norms as an aspect of the developing person. Parson's brilliant treatment of this neglect, and his reformulation of the concept of the "super-ego" in relation to acculturation seems to me to bring together the issue of cathexis and cognition in a kind of relationship which is essential to an understanding of process. Developments in the therapeutic field, no matter how misguided one may assess them to be, seem to me to be increasingly in the direction of a consideration of the rational or cognitive elements. Family therapy, when it is more than a vogue, seems to me to be an explicit recognition of the primacy of cultural objects, with their structural and cognitive elements as well as their cathectic qualities, as important aspects of the treatment situation.

The attempt of this symposium to bring together an understanding from both "sides" seems to be in line with the "ecumenical" temper of the

times. The exclusive concern with the intrapsychic qualities of the person, and in the group the intrapsychic qualities of the "group minds," reminds me a little of Dante's description of Francesca and Paola who were condemned to whirl rootlessly throughout eternity clasped in each other's arms as the punishment for their illicit love. The recognition of the cognitive element promises to bring back the treatment situation to the structural properties of the culture and to connect in a meaningful way that which is *felt* about the object to that which is also *perceived*. Social psychology seems to me to have been most successful when it has related the perceptions of persons to the kind of relationships which express themselves interpersonally. Clinical situations tend to record many of the anxieties related to structural ambiguities in modern life.

A dialogue between therapist and experimenter seems to me to be essential if the kind of meaningful generalizations which we all hope for are to be realized. A dialogue contributes many things: it may reduce the excess baggage which we have thought was so essential to our explanatory equipment; it may also bring about the kind of questions which are fruitful to investigate rather than issues which seem to lend themselves to rather clever manipulation but lack any systematic anchoring and any significance for application. Unfortunately, much of the work in the area of small groups I would place in this category. Such a dialogue would come at a time when many are increasingly skeptical of the fruits of psychotherapy as well as the productivity of much of the research in social science. The conclusion that indeed there is a discrepancy between private feelings and public commitment in a small group, if left at that point, seems about as inconsequential as the endless retelling and "rediscovery" of the oedipal complex. Much of the literature on both "sides" has this trivial character.

Drs. Semrad, Kanter, Shapiro, and Arsenian have contributed a plausible survey of the clinical issues. If these issues remain in their present state, unexamined by the processes of inquiry by which we come to have a knowledge of things, then they are likely to become a series of platitudes, or they are likely to harden into a rigid and compelling dogma. Since Dr. Semrad and his collaborators have been neither platitudinous nor dogmatic, they have given us a view of the work which needs to be done. The presence of us all here shows our disposition to do it.

THEODORE M. MILLS, Ph.D.¹²

In his essay on "Procedure in a Science," L. J. Henderson presents as two of three requirements in science making, (1) intimate, habitual, intuit-

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tive familiarity with raw processes, and (2) a systematic means of collecting reliable and relevant facts. Curiously, persons interested in groups have tended to differentiate their professional careers chiefly according to these two requirements. The clinical observer and practitioner has immersed himself in group process: he "seeks a feel for it." And the detached experimentalist, or systematician, collects his objective data.

The first step in closing the gap is an exchange of methods between specialists. Such exchange, however, is but a first step. Closing the gap in a truer sense involves Henderson's third requirement, namely, an effective way of thinking about the phenomena. The gap itself is engaged when those who possess an intuitive familiarity and a means of gathering objective data attempt to formulate an effective conceptual apparatus to clarify our thinking.

The paper by Dr. Semrad and his colleagues speaks for the habitual, intuitive familiarity its authors have with group processes; and, I think, it represents the struggle that is necessary in order to move from that concrete level toward the level of the third requirement: an effective way of thinking about the phenomena.

In response to it, I have two points. The first is a question of clarification regarding the constructs, *cooperation*, *competition*, and *conformity*. The second is about systematic collection of data.

As constructs designed to aid our effective thinking, what do cooperation, competition, and conformity refer to? What sort of concepts are they? Given a goal (to paraphrase the paper), presence and contact sets in motion a process. Through time, the psychological field of forces changes. Cooperation, competition, and conformity are manifestations of these changes. They refer to complex emotional processes. They imply purpose and differ in maturational quality. They are modes of interpersonal negotiation.

These points are guides, but they do not take one all the way home to an understanding of the nature of the constructs. The constructs contain more than needs and wishes; there is also action, reaction, communication and its consequences. They contain more than a pattern of behavior, for they imply purpose.

Are they not ideal-type constructs representing, in each case, approaches to a particular arrangement of values, attitudes, norms, feelings and overt behaviors as this arrangement exists between persons? If so, the problem they are designed to handle in the group parallels the problem sociologists and anthropologists have experienced in trying to point up those particular combinations of things which make a civilization unique, or a society distinct, or a period of history memorable. As one example, Comte formulated three stages in the evolution of societies: the theological, the metaphysical, and the scientific, each being captured in their es-

sential arrangement and emphasis by Comte's mental constructs of theological, metaphysical, and scientific.

As constructs (though perhaps not in substance) do *cooperation*, *competition*, and *conformity* serve theoretical purposes similar to Comte's concepts? Does it make sense, and is it useful, to think of a cooperative society, or of a competitive one? Or, looking at smaller segments of society, do its institutions, such as the family, the market place, the industrial plant, etc., differ in cooperation, competition, and conformity? In what way do these constructs enable us to deal with complex arrangements of values, attitudes, feelings, and behavior? Are they, for example, similar to the sociological construct of *bureaucracy*? Here we have one form of interpersonal negotiation and a concept which captures an immensely complex arrangement of values, attitudes, norms, and feelings. Moreover, it is a construct of immense utility to the sociologist because, for one thing, it enables him to deal with a very complex situation independently of the personalities of those filling given positions in the situation. Is the construct *cooperation* designed to capture an order of phenomena in the group abstractly similar to that represented by such constructs as *bureaucracy*?

Or, to pursue the question in a different quarter, can we take games as another set of complex arrangements of interpersonal negotiations which, in their full play, assume and demand an intricate arrangement of norms, attitudes, emotional relations, and behaviors? As constructs, are cooperation, competition, and conformity attempts to formulate the nature of potential games of group process: what they, as "process-games," involve, how the games change, how their purposes differ, and what level of maturation they demand? If so, then they clarify for me the authors' interpretation of the leader's role in acknowledging, tolerating and placing in perspective "the emotional complexities," or, in terms of this comment, the game being played by the group. Are not interventions often asking, in effect, "What is the nature of the game we as a group are playing?" If the triad of constructs, cooperation, competition, and conformity, are in this sense similar to our concept of game, might they not be attempts to formulate the essential structure of the situation to which group members are responding?

Further clarification and more precise formulation of these concepts will be valuable, for it can add to the fruitfulness of moving to the next questions Dr. Semrad and his colleagues raise: namely, what does it take for a person to play these games fully? What does play do *to* and *for* him? In more general terms, what is the interaction between "process-games," actual and potential, and persons, singly and collectively?

My second point regards Henderson's requirement that there be a

systematic method of collecting data, and, if I may add, collecting data which test ideas born of familiarity with the phenomena.

I do not know whether the hypothesis of the leader as scapegoat is correct or not, nor do I know the probabilities of its being correct. I do suggest, however, that it can be tested. It is stated in testable form, and methods have been developed in the social science laboratory which enable a test.

I ask your indulgence if I present a note of personal history which seems relevant to the central theme of this symposium: the relationship between the practice of group psychotherapy and scientific research on group process.

Five years ago in a research group at the Massachusetts Mental Health Center the hypothesis was stated by Dr. Semrad. Since then, I have been attempting to test it experimentally in the laboratory. Over the past two and a half years, thirty groups have been run.

It may be of special interest to this group to know the changes that had to be made in our usual procedures in order to accommodate an hypothesis of this order. You will recognize as well that some of the features of psychotherapy groups had to be given up. The aim was to simplify, but to retain the essentials.

1. It was advisable to simplify the statement of the hypothesis: As negative feelings directed toward the authority in a group increase, the probability of mutual positive relations between members increases. The probability of negative feelings toward the authority will be greater when parties (subordinate authority) are of the same sex than when of different sex.

2. Instead of having experimental groups meet for one or two hours, it was thought necessary to run them for at least six weeks. It has taken, as I have said, two and a half years to produce the data rather than three weeks.

3. The number of members of each group was reduced to three persons: instructor and two students.

4. It was thought essential to present to subjects a group activity with a meaningful purpose, a sensible goal, and a reasonable possibility for genuine gain on their part, activity which could stand in its own right irrespective of the experimental purpose.

5. A two-month training period was instituted for group leaders, so that they might more nearly approach the role of supporter, target of aggression, and symbol of work.

6. An attempt was made to measure latent group processes as well as the observable behavior, reportable attitudes, and feelings, etc.

The purposes of this report are to suggest that gaps between clinician and experimentalist can be closed and to emphasize the central importance of Henderson's last requirement: namely, an effective way of thinking about the phenomena. Before tests can be made, propositions must be clear. Because of the expense of time and funds and facilities, it is advisable that the propositions be relevant and important. Clear and comprehensive theory is our first need. Our second is more economical experimental testing procedures. Often our reluctance to work through to a clearer proposition on important matters and to commit ourselves to a single proposition arises because we sense how expensive it would be to test it—and to learn what the probability is that it is true.

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A REVIEW OF SMALL-GROUP RESEARCH FOR GROUP THERAPISTS¹

A. PAUL HARE²

This paper is designed as a report on current trends in small-group research for persons concerned with research or practice in group psychotherapy. Small-group research, as it is defined here, typically deals with interaction in a small problem-solving group. Usually the group is a discussion group, and quite often the research is done in the laboratory with a group brought together for the purpose of research. Since a therapy group is also a small discussion group, the literature on therapy groups might well be included in this review, and in fact, some research on therapy groups which considers the therapy group as an example of one kind of group is included. However, research concerned with the special "therapeutic" aspects of such a group has been omitted.

Small-group research, in its present form, began around the turn of the century with the work of Puffer on boys' gangs (1905), Simmel on group size (1902), Cooley on the primary group (1902), Terman on leadership (1904), Triplett on social facilitation (1898), and Taylor on group norms (1903). One can make a case for the proposition that most of the central ideas and methods in small-group research were presented by these men before 1905 and that much of our present research is simply a variation of this early work. However, the major emphasis on small groups or group dynamics did not begin until after World War II. Within the field of small-group research there have been three main traditions. The earliest of these is represented by the work of Moreno in his *Sociometry Reader* (1960). Next is the work of Lewin and others who work in group dynamics, which has an applied emphasis as well as a research emphasis. As an introduction to this tradition, Cartwright and Zander's *Group Dynamics* (1960) gives the best overview. Finally, the Bales tradition is represented in the readings, *Small Groups*, edited by Hare, Borgatta, and Bales (1955). Of course, there are many, particularly in the area of leadership, such as Bass (1960) or Stogdill (1959), who are somewhat independent of these traditions. For a survey of the whole area, both in content and in method, the chapters in Lindzey's *Handbook of Social Psychology* (1954) is a good place to begin. A more recent survey which also covers the earlier material is given in the *Handbook of Small Group Research* (Hare, 1962). Since the

¹ This paper was presented at the 8th Annual Research Conference of VA Cooperative Studies in Psychiatry, Kansas City, Missouri, March 1963.

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handbook only goes as far as 1959, one might wish to read Shaw's article on "Group Dynamics" in the *Annual Review of Psychology* (1961) for the 1960 literature. Most of the research in 1961-62 tends to follow the same themes represented in the earlier research, often replicating earlier findings. A first-hand impression of this literature can be obtained from the *Journal of Abnormal and Social Psychology*, *Sociometry*, and *Human Relations*, where most of the more relevant articles appear.

The research findings from small-group research may be organized in at least three different ways. One may be interested in generalizations about group process and structure and focus on norms and social control, the interaction and decision process, roles within the group, or on interpersonal choice. Or one may be interested in variables which affect the interaction process, such as personalities of members, social characteristics of members (i.e., age, sex, social class), group size, group task, communication network, or leadership. Or, finally, one may be interested in the performance characteristics of groups and may focus on the productivity of individuals compared with groups or on groups with differing types of organization. Over the years there has probably been more research relating to leadership than any other topic (cf. Petrullo and Bass, 1961), with the "sociometry" of interpersonal choice running a close second. During the last five to ten years, however, there has been a preoccupation with the issue of "conformity," especially with the tendency of "authoritarian" individuals to yield to various types of social pressure. The collection of articles in *Conformity and Deviation* by Berg and Bass (1961) provides a comprehensive summary of the research in this area.

INTERACTION AND DECISION PROCESS

To provide a sample of the findings of small-group research having special relevance for group psychotherapy, I shall quote from the summary of the chapter in the *Handbook of Small Group Research* (Hare, 1962) which covers the interaction and decision process. We find that the observation and analysis of the interaction process usually depends upon a category system which allows the observer to code each act in one of a limited set of content areas. Current usage of category systems is represented by the work of Stock and Thelen (1958), who give a double score to each act by noting the amount of task and social-emotional behavior it contains, and by Bales (1950), who scores each act on its predominant content. The Bales' system has twelve categories, which are subdivisions of four general types of acts: positive reactions, negative reactions, problem-solving attempts, and questions.

In the typical interaction of a small leaderless group, there is a balance

NEW DEVELOPMENTS IN THEORY

Some years ago, Strodbeck and I (1954) asked several judges representing different "schools" of small-group research to select the outstanding pieces of research. The most highly rated books were those by Moreno (1931), Jennings (1943), the OSS Assessment Staff (1948), Bales (1950), Homans (1950), and Cartwright and Zander (1953). I do not know how these judges would cast their votes today, but if they had a chance to read it, I am sure that they would rate the doctoral thesis of Arthur Couch on "Psychological Determinants of Interpersonal Behavior" (1960) as one of the outstanding present-day contributions to the field. But why single out Couch? Partly because his thesis represents a kind of turning point in methodology—no one before had made such extensive use of factor analysis, and now that computer programs are available, anyone who wishes to can do the same—but mostly because he presents a kind of closure to a quest for predictability in interpersonal behavior that has been going on for a long time.

Couch is working in the analytic tradition begun by Freud and represented more recently by the work of Leary (1957). His subjects were Harvard undergraduates in 12 five-man groups. Each group held five meetings with a series of discussion tasks. Interaction was recorded by Couch, Bales, and Kassebaum using three different category systems. After each session subjects responded to a battery of "postmeeting reaction" questions. Each subject also took a large battery of psychological tests including the MMPI, Cattell 16 P. F., Thurstone Temperaments, Value Profile, and other tests devised for this experiment. Twenty-four of the subjects were also part of another extensive clinical research project. For the analysis summary, scores of behavior over all five meetings were used for the 58 subjects on whom complete data were available.

Couch began with the basic assumption that an individual's pattern of overt behavior is multidetermined by the following sources of tensions: (a) his underlying *Needs*, (b) his *Concealment Defenses*, (c) his *Apperception* of the interpersonal press around him, and (d) his reaction to the *Behavioral Press* of the overt acts that are directed toward him by others in the same situation (An abstract of this formulation is given in Couch, 1961). He then proceeded to do a factor analysis of the variables in each domain and was able to show that the two independent factors of *Interpersonal Dominance* and *Interpersonal Affect* appeared at each level.

For his first round of final correlations, Couch compared the personality measures for the subjects with their behavior scores for each of the two factors. The correlation for Dominance was .35 and for Affect .33. Both of these correlations are significant at the .01 level. Had he stopped here,

Couch would have done better, but not much better, than the average correlation between personality test and behavior of about .20 reported by Mann (1959) in a review of research in this area.

Couch then added to his measure of Personality Need a measure of Concealment Defense on the assumption that subjects who were high in Concealment would tend to inhibit their actual behavior along the dimensions of dominance and negative affect. The new correlations between Need plus Defense and Behavior are .53 for Dominance (a significant increase) and .32 for Affect (no change). By adding Apperceived Press the correlations rise to .64 for Dominance and .41 for Affection, a significant increase in both cases. Finally, adding a measure of Behavioral Press to the previous index, the correlations reach .88 for Dominance and .66 for Affect, again a significant increase in both cases.

Thus, Couch has "explained" a large share of the variance in behavior in small groups. But those of you who wish to predict behavior as well as explain it may be disturbed by the fact that measures at two levels can only be made *after* the interaction has occurred, namely, Apperceived Press and Behavioral Press. In fact, if you observed that the correlation between Behavior and Behavior Press (or output and input) was .84 for Dominance and .61 for Affect, you might be concerned that such a small amount of the variance remained to be explained by personality variables. Of course, as Couch points out, the measures of Apperceived Press and Behavioral Press are not entirely independent of Personality Needs. The individual, as Leary has remarked, tends to "pull" a kind of behavior from other group members that meets his needs. His needs also tend to influence his perceptions of other's behavior. Nevertheless, Couch has made at least two definite contributions to our knowledge of interaction in groups. First, he has shown that the concept of Concealment Defense is useful in understanding part of the discrepancy between measures of Personality and Behavior, at least for the factor of Dominance. (Others have had difficulty with the dimension of affection also, possibly because it is not related to activity rate; cf. Schutz, 1958, and Breer, 1960.) Second, he has shown that a large part of the variance in an individual's behavior is to be found in his response to other members of the group. Perhaps, then, for the typical problem-solving group, we can never push our correlations between personality and behavior much beyond .30 simply because there is no more variance to be accounted for by premeasured personality characteristics of the subject.

But what can we gain if we consider the personality traits of the other member of an interacting pair? Breer (1960) provides part of the answer in research on small laboratory groups similar in many ways to those studied by Couch. Breer also used the Leary framework together with a theory of interpersonal exchange based on the work of Homans (1961). To

predict how ascendantly a subject would behave toward some other particular person in the group, Breer composed an index based on those attributes of the other person thought to correlate positively with his ascendancy (intelligence, age, sex, social class, and pretested dominance). This index was subtracted from an ascendancy index based on measures of the subject. This was done on the assumption that the more ascendantly the other person behaved toward the subject, the less ascendantly the subject would behave in return. For the prediction of affectionate behavior, the index also included the characteristics of the other three group members.

The correlation between this combined index and an ascendancy-submission behavior score for a set of pairs from Breer's groups was .62, compared with a correlation for a preinteraction measure based on characteristics of the subject alone of .51. The correlation between predicted and observed affection using a similar index was not as marked, only .33.

Neither Couch nor Breer considers the within-group roles of the group members as a possible source of variance, mainly because small, initially leaderless groups are not usually thought of as having well-defined roles. Because of the laboratory setting of so much of the small group research, there have been relatively few examples of studies combining premeasures of personality and role. The work of Haythorn et al. (1956a, 1956b) provides a good example of a "precomputer" attack on the problem of authoritarian and equalitarian personality types in leader and follower roles. One would be able to do a lot more with the data at the present time.

But then suppose we add measures of role to our research, must we also add measures of the influence of majority opinion, or group size, or any of the other "variables" that have been shown to have some effect on small-group behavior over the past 60 years? Probably yes. But this is not a job for men; it is a job for a machine. Part of the answer lies in computer programs to simulate interpersonal behavior and part lies in more comprehensive computer methods of data analysis.

But, if you are a practicing therapist, do not suspend meeting of your therapy group until the results of current research are in. Those of us who work in the laboratory have some distance to go before we can match the insights based on clinical experience of men like Leary (1957) or Bion (1961). But given the present state of theory and methodology the future has never been brighter.

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RESEARCH IN THE STRUCTURE OF GROUP PSYCHOTHERAPY

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At a recent meeting of the American Group Psychotherapy Association, one of the participants was asked by a reporter, "What, really, is group psychotherapy?" Cued by the reporter's unconsciously hostile "really," the therapist said, "Group psychotherapy is what group psychotherapists say they do and what individual psychotherapists say should not be done." In a more serious vein, after noting the reporter's hurt that his hostility had been remarked, the therapist continued:

Actually, group therapy is many things. As I have listened to the papers over the past several days, I have become convinced that the common element among many of these techniques is that there are several patients present in the room while the therapy is going on. Much of what I have heard here, from my point of view, I would call aggregate therapy, that is, therapy taking place with an assemblage of relatively unrelated people. Some I would have to call public therapy, that is, individual psychotherapy taking place with an audience. I call my own work group therapy because I try to deal with an entire group, hoping that this will sustain or cure the individual members. To be just, group psychotherapy is a young field and too little is still known about its subject matter to evolve more than tentative definitions.

As an anthropologist I can sympathize with the feelings of the therapist. However, he should not feel guilty because he cannot define exactly what a therapy group is, what it does, or how it is influenced.

RESEARCH IN GROUP THERAPY STRUCTURE

Read Bain, for a number of years the dynamic editor of *The American Sociological Review*, used to complain bitterly that "group" was one of the clumsiest and most inadequately defined concepts in the social sciences. Like "family," "group" comes directly out of folk, nontechnical usage, is deceptively overfamiliar, and through its apparent simplicity and visibility masks out the very phenomena it seems to elucidate.

Goffman (1961) suggests that much of the difficulty in the definition of

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"group" comes from the confusion occasioned by the failure to distinguish between two similar but clearly differing social phenomena. His research indicates, as does ours from a quite different point of view, that it is profitable to differentiate a "social group" from "focused gatherings":

A social group may be defined as a special type of social organization. Its elements are individuals. They perceive the organization as a distinct collective unit, a social entity, apart from the particular relationships the participants may have to one another; they perceive themselves as members who belong, identifying with the organization and receiving moral support from doing so; they sustain a sense of hostility to outgroups.² A symbolization of the reality of the group and one's relationship to it is also involved [p. 9].

This may be contrasted with a focused gathering which, while it may become a social group, is identifiable by a concentration of behaviors non-typical of the more self-aware group.

Examples of such properties include embarrassment, maintenance of poise, capacity for nondistractive verbal communication, adherence to a code regarding giving up and taking over the speaker role, and allocation of spatial position. . . . A crucial attribute of focused gatherings [is] the participant's maintenance of continuous engrossment in the official focus of activity . . . a coming-together can be merely a phase of group life; a falling-away on the other hand, is the end of a particular encounter,³ even when the same pattern of interaction and the same participants appear at a future meeting. . . . There are many gatherings . . . where an extremely full array of interaction processes occurs with only the slightest development of a sense of a group [p. 11].

Goffman's distinctions are useful because they stress the importance of the consciousness of group membership as an important determinant of the kinds of relationships established, maintained, or even, perhaps, terminated by participation in such organizations. Ross Speck and Gregory Bateson⁴ have, in reference to quite different kinds of data, remarked on how difficult it is for members of schizophrenogenic families to have mem-

² I do not find "hostility" a necessary requirement for this definition. Groups can be either "open" or "closed," i.e., hostile to outsiders or receptive with well-ordered rules for inclusion.

³ I reserve the term *encounter* for that search behavior of the organism prior to the establishment of interactional patterns characteristic of the particular interactants in whether a two, a three or a multi-person system. Goffman's encounter is used here to preserve the integrity of his quotation.

⁴ Private communications.

bership in a social group as defined above. They seem to be impeded from participation in such groupings because involvement in them would necessitate some kind of disloyalty to their peculiar family adaptation. On the other hand, it is quite clear that members from such families often have reasonably successful adjustments in focused gatherings—at least these adjustments seem successful so long as the focused gathering does not become a milieu which tempts them into the inappropriate pairing-off or overcloseness so characteristic of their symptomatology. Clinical reports indicate that therapy groups break up because of situations like this.

Goffman's is not the only way, however, of delineating social groups. From the point of view of the anthropologist concerned with communication studies it has the shortcoming that it is overdependent upon the individual's awareness of his membership. Such awareness often comes long after the group has been in systematic operation. If we are concerned with problems involving group formation, change and dissolution, or with problems relating to methods for inclusion of new members or the loss of old ones, such ideal categorizations may not be sufficiently sensitive to illuminate the data which we seek to comprehend.

The more traditional division of group into "formal" and "informal" organizations is even less useful. Such a division usually stresses the presence of explicit rules in the former, less explicit (or completely implicit rules) in the latter. Again, for some purposes this is a useful distinction, but from the point of view of the communication analyst, it may create more problems than it solves. In order to make efficient use of this dichotomy, if we are interested in determining the kinds and the relative strength of the interactions possible within these structures, we have to know something about the relationship between the presence of recognized rules and the observed behavior. Further, to be meaningful to us as distinctions of kinds of groups, we need to know something about the kinds of orderings of behavior which take place when a group is governed by an implicit code. At the moment I do not believe we can even say which organization, "formal" or "informal," contains the more ordered behavior. Common sense and democratic preconception would lead us to believe that an informal grouping is less ordered and more conducive to change both within its membership and in its own structure than would be the formal. However, our own preliminary research indicates that extensive rule establishment may at times create an environment far more conducive to growth and change. As in the case of Goffman's concepts, these are deviations useful in that they focus our attention on certain kinds of behavior. They can be destructive concepts if they give us premature closure. I need only listen to a discussion between a therapist who stresses intervention and one who is permissive or "acceptive" and then observe them and their groups in

interaction to see how preconception can govern self-perception—and how little it, at times, has to do with operation. I have seen self-styled authoritarians establish limits which only gave order to the multiple adaptations of change in group behavior, and I have seen therapists devoted to an acceptance milieu signal only the removal of limits which encouraged change. However, only extensive research can finally determine which of these are the more therapeutic.

There have been a number of other definitions of kinds of groups. Each seems to have useful features for certain kinds of problems. However, none are sufficiently delicate to permit us measurement of the kind we need to have if we are to solve the problem of describing the comparative efficacies of various group psychotherapies. Of a different order of approach have been those techniques which define the group as some kind of assemblage of dyads, triads, etc. The fact that any observed grouping can be seen to have for N amount of time X number of abstractable relationships does not make a group merely the sum of the relationships to be seen in its context. Again, the study of relationships is subject matter in and of itself. And it is an important area for research. If we are ever going to understand group therapy, we must understand relationship formation, homeostasis, and dissolution. However, this is going to require extensive behavioral research. Scheffen, in an unpublished study of the Whitaker-Malone therapy, has clearly demonstrated that these are not to be detected by simple attention to verbal material. He has told me that it looks likely that research is going to substantiate his hunch that often the verbal data is delusory and serves only to mask out the more essential reciprocalities in interaction.

All of these distinctions are meaningful for the student of structural communication analysis. Unless the student is so omnivorous in his conception of communication that he defines it to include all of culture, he must have distinct, or at least heuristically distinguishable, contexts for the measurement of the behavior which he is attempting to order. If he is going to study the communicated shifts of behavior in groups, he must know the context of these occurrences. Only in this way can he isolate the strictly communicational behavior from the idiosyncratic, on the one hand, and from the institutionally internalized, on the other.

For the purpose of this paper, communication can be regarded as, in the broadest sense, *a structural system of significant symbols (from all the sensory-based modalities) which permit ordered human interaction*. We are not, as students of communication, concerned with the Army, for instance, as subject matter but we are concerned with the militarily influenced situation as a structure which gives special meaning to a symbolic act. Similarly, we are not concerned with the family as a communicative

activity; we are concerned with the family as a matrix which elicits, permits, or prevents certain kinds of symbolic acts which we are better able to understand if we know the structural pressures imposed by the system. We are not concerned with either schizophrenia or psychiatry, or even with Dr. Miller, psychiatrist, and Mr. Smith, patient, when we examine the doctor-patient interaction; we are concerned with the situation as an ordered matrix which makes the delineation of communicative acts or systems more comprehensible.

Let me hasten to say that, as behavioral scientists, we are, of course, hopeful that by the delineation and description of communicational behavior, we can shed light on military, familial, or therapeutic matters. However, we have made the methodological judgment to study the communicational system.

As anthropological linguists or kinesicists or, emergently, as students of communication behavior, our primary task is that of isolating structural meaning. That is, we seek to order vocal and body-motion behaviors in a way which will make it possible for us to understand their structural properties. We must, if we are to do more than impressionistic or judging or dictionary studies of the meaning of the events that make up the communicative process, understand the nature of the linguistic or kinesic systems themselves. We need them to know how these are related to each other and what the emergent communicational units are. We now know that *neither words nor gestures are the essential units of the communicational structure*, but we do not, as yet, know enough about either of these or their association to know the shapes and sizes of the presently only vaguely conceptualized semeiotic or communication units. Nor do I believe that we are going to be able to weigh the effect of either words or body motion complexes in interaction until we know enough about the matrices of their occurrence to study them. As our studies approach the point where we must deal with *social* meaning, we need clear statements regarding the structure of the *social* contexts of communicational occurrences. It is difficult, if not impossible, to answer the question: what does this symbol or that gesture mean? Meaning is not immanent in particular symbols, words, sentences, or acts of whatever duration but in the behavior elicited by the *presence or absence of such behavior* in particular contexts. The derivation and comprehension of social meaning thus rests equally upon comprehension of the code and of the context which selects from the possibilities provided by the code structure.

Let us rephrase this. As Hockett (1960) has so clearly pointed out, if it is to accomplish the multiplicity of tasks inherent in its role as a primary communicative channel, no language can be merely an assemblage of signs, each sound having a specific and exclusive referent:

One of the most important design-features of language is 'productivity,' . . . the capacity to say things that have never been said or heard before and yet be understood by other speakers of the language.

It is my own experience that this design-feature is possessed, too, by body-motion language. The study of body-motion communicational behavior, kinesics, is convincing even at this preliminary stage of development, that body-motion behavior, like vocalic behavior, is composed of a limited (society by society) list of distinctive elements that are, by rules for coding, combinable in a virtually infinite number of ordered combinations to order the communicative aspects of human behavior.

It is not enough, however, to know that both body-motion and vocalic behavior are ordered systems of isolatable elements. To repeat, the most comprehensive knowledge of linguistics and kinesics (*qua* linguistics and kinesics) will not permit us to analyze the precise social meaning of the content of an interactional sequence. On the other hand, we can, from the stream of audible sounds and the visible motions interchanged by the membership of the group, detect, isolate, and describe the nature of the behavior, linguistic and kinesic. Thus, we may be able to discover and describe our discoveries in ways which make it possible to test our judgments of the following: (a) The social genesis of the behavior (if from known systems). That is, we can determine, within certain limits, the dialectual and areally-defined body-motion background of the speakers. (b) We can determine whether these are "standard" or "nonstandard" communications. That is, we can make certain inferences as to the socioeconomic background of the participants. (c) We can, within limits, define pathology in the performance as evidenced in internal inconsistencies of performance. (d) We can say something as to the range of activity occurring in the interaction. That is, is this a highly limited and controlled performance or is it a loose, relatively unstructured and malleable one. (e) We can determine the extent to which there is adaptation or resistance to communicative adaptation among the members. (f) We can determine signalled internal inconsistencies or consistency in the social performance and often we may be able to detect signalled reactions to this degree of consistency. Most important, we can say these things in a way which makes it possible to test our judgment.

However, if we want to discuss social meaning of any particular element of behavior, if we want to distinguish appropriate from inappropriate behavior in a given scene, if we want to discuss how much information passes between the membership, if we want to know whether effective accomplishment of therapeutic or educational purpose results from the interaction, or if we want to talk about the effects of this particular interaction upon the participants in other situations, we must know a great deal

about the nature of the social context within which the particular communicative acts take place.

I stated above that I object to any attempt to subsume all social behavior under a linguistic, kinesic rubric. I do not think that, as presently conceived, all interactive behavior should be relegated to a communicational or "semiotic" frame. However, I equally object to any conceptual scheme which suggests that the linguist or kinesiologist should only be concerned with single utterances or movement sequences, whether studied from the point of view of the performance of a single actor or from the equally atomistic position of those who conceive of the world as made up of people who alternately speak and listen or move and watch. Focus upon the actor and the reactor serves only to obscure the systematic properties of the scene, whether viewed from the sociological or the linguistic-kinesic-communicational point of view.

At the present writing, it seems likely that styles of communicating, orders of choice of communicative items, and, even, orders of choice of sensory modality for participation may very well be so structured and so related in a hierarchical manner to linguistic and kinesic systems that they will fall within the province of the linguistic-kinesic analyst. It seems, moreover, that communication and interaction situations must, for comprehension, draw from psychiatric, social psychological, sociological, and anthropological research. As each discipline develops explicit descriptions of the orderliness of the phenomena at each level of organization, these descriptions of behavioral meaning should progressively contribute to delineate the range of social meaning of the particular activity of the particular interactants of a particular situation of a particular social grouping of a particular society. If we can control such knowledge, we can then describe the behavior present in group or family therapy situations in a way that will make objective evaluation more efficient and reliable.

Let me put this in another way. We have some rather specific, but at the present time, unanswerable questions. What we need to know is whether group (or family) therapy in a particular group or family is like Goffman's first group, a social group. Or is it a focused group? Or are there other kinds of groups with different dynamics than either of these? Does a focused group evolve into a social group during the course of a therapeutic endeavor? If so, what effect does this have on therapy? Does the social group as a tighter organization have homeostatic functions which make it resistant to change on the part of its membership? Or, alternatively, does the group as a system, as it is moved toward new adaptations, take its membership toward "better" individual adjustments? Is the therapeutic situation a haven, a temporary, recognizably ordered universe which gives its membership sufficient reassurance of predictability and sanity that the

individual participant can "make it through" the remainder of the day? Or does the group "experience" serve to change the individual member so that he can leave the group and become a functioning participant in the remainder of society? Who and what is the therapist in all of this? Is he a chairman, a steersman, a judge, or a gyroscope? And what happens if the therapist and one of the patients become exclusive or inclusive pairs within the group?

Obviously, none of the answers to these questions is going to be in simple either-or form. Scheffen and I have, for the past four years, been studying individual therapy. If there is one single conviction that we have arrived at from this investigation, it is that such questions cannot be answered by interviewing the participants. This is not to say that the therapist and the patient are not willing, even anxious, to give answers to questions such as these. It is only that, under investigation, such answers turn out to be data which require as much research to understand as did the original behavior. What we need are multilevel methods of analysis and description which will make it possible to examine therapeutic situations, abstract their salient features, and test their efficacy. This is no different than the requirements for any clinical technique: chemical, surgical, virological, or bacteriological. Until recently the data of the therapeutic situation could not be recorded in a manner that was not so intrusive that it did not distort the therapeutic procedure beyond examination, but recent developments in the technology of sound movies and in techniques for their analysis have made psychotherapy subject to objective evaluation. However, the communication analyst, the anthropological linguist or kinesiologist, while he can contribute to studies such as these, cannot provide all the tools for such research. We must have the data accessible to the skills of the sociologist, the social psychologist, and the research psychiatrist. This requires multidisciplinary research.

Obviously, such investigation will require an ambitious and long-range program of research. To some it may seem a scientificistic overstructuring of methodology, an elaborate investigatory endeavor which will provide the practitioner with "more than he wants to know about penguins." However, unless we recognize that the group is *not* merely an assemblage of individuals, the sum of whose behaviors constitute the behavior of the group, we are destined to be caught in an atomism so obscurationistic that success in teaching or group therapy can be no more than happenstance. From my own point of view, it is time that we lay out long-range programs in research on groups and group behavior. The accumulating data from such research will provide material by means of which techniques of group therapy can be taught rather than simply learned or imitated. The presently available teaching material with few exceptions is thin, scanty, and anecdotal.

dotal. By and large, teaching of group therapy today is based upon the clinical case method, which is time-honored as a method for the production of a small number of excellent clinicians with special talents for extensive association with individuals. At the present writing there is no clear indication that such training (other than of the skills associated with diagnosis and prognosis) has much to do with the production of skilled group or family therapists.

Within the past few years, techniques of group therapy have been accepted by an increasing number of administrators and an increasing number of practitioners have been willing to invest an increasing proportion of their energies to its practices. Without being cynical we can recognize that with the great pressure of case applications, administrators are forced today to test any responsibly sponsored method which can reduce the pressure. The popularity of group therapy for the practitioner is a much more complex matter. However, even though there are leaders in the group therapy "movement" who act as though they feel that group therapy must still be sold to a resistant public, the truth of the matter is that both family and group therapy has become an established fact. This paper, in complete sympathy with the goals of a therapy which utilizes the strengths of a group to reproduce geometrically the energies of the therapist (or the therapeutic team) in ameliorative or curative endeavor, is written in the conviction that a responsibility goes with this social acceptance. If group or family therapies are to become applied sciences, their practitioners are going to have to learn about and teach their best methodologies. Otherwise, the fields will be restricted to "natural" therapists who brilliantly perform therapeutic exercises which are nonrepeatable by less gifted colleagues. "Scientific" societies associated with these therapies will become debating societies in which competitive philosophies will take precedence over case and research presentations of material which could illuminate, instruct, and contribute to a body of tested knowledge. The young practitioner must have such material if he is to make an informed choice of measures appropriate for particular cases. The group psychotherapy instructor must have such material if he is going to train the number of therapists needed in a mental health conscious world.

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BOOK REVIEWS

Edited by BERYCE W. MacLENNAN, Ph.D.

GROUP PSYCHOTHERAPY: THEORY AND PRACTICE. By *Hugh Mullan* and *Max Rosenbaum*. New York: Free Press of Glencoe, 1962, 373 pp., \$5.95.

All workers in the vast field of psychoanalytic group psychotherapy will greet this book with enthusiasm. A student just starting will benefit from it just as much as the experienced practitioner who wishes to deepen and expand his knowledge and understanding. The book, beautifully and lucidly written, is based on a careful study of the literature and on years of experience in group psychotherapy, soberly reported and analyzed.

The authors give answers where they know them, but, more importantly, they show the methods and technique of proceeding in the complex field of psychoanalytic group psychotherapy. There has been a great need for a theoretical and practical book which describes the methods of selection, preparation, and introduction of patients to a group, as well as the hour-by-hour work that group therapy entails. This book fills that need and may well become a widely used textbook of group psychotherapy.

The book opens with a historical survey of the literature, followed by a description of fundamental concepts, and then goes into the details of the process of patient selection and preparation for group psychotherapy, ending with a description and analysis of the group process. A special chapter deals with transference and countertransference problems. The last part of the book describes and outlines training methods and training programs.

Later editions of this remarkable book should perhaps include a special chapter on the place of family therapy within the field of group psychotherapy; however, even this special aspect receives some mention within the covers of the present volume.

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GRUPPENSTRUKTUR UND GRUPPENLEISTUNG. By *Hardi Fischer*. Berne, Switzerland: Verlag Hans Huber, 1962, pp. 136, sFr. 23.80.

Number Two of the Series of Social Psychology is devoted to the study of the individual in isolation and in his interaction (*Wechselwirkungen*) with social contacts. The author starts from the thesis that the productivity of each member of a business concern is dependent on the "team" as a whole. However, the gap between "mood" or "attitude" and "accomplishment" is seen daily in enterprises everywhere. Perhaps automation has increased productivity "somewhat," but individual accomplishment has de-

creased. There seems to be no doubt that today's younger people are used less in the machinery of business organization and that less initiative and "active presence" are required of them because modern machines and a "better social order" make the youngsters' daily tasks "easier."

In this study, the author first presents a survey of present-day psychological research on the theory of small groups. He attacks the core of his study, *Struktur und Leistung* (structure and accomplishment), from two angles: a theoretical and an experimental-psychological. He elaborates on the former by means of illustrating several models. These models are mostly mathematical analyses of structure: "Graph-Theory" as a special chapter of topology, *Matrixrechnung*, and theory of information and communication. Concerning the experimental-psychological point of view, he presents various laboratory experiments, which constitute but a small part of a great many experiments. The author mentions that there is a discrepancy between the theoretical model and the experimental *Nachpruefung* (verification), and he attempts to analyze the verification of his experiments in his concluding chapter. While there is no bibliography, there are footnotes, just sufficient to refer the student of group dynamics to the author's principal guides in the literature of group dynamics, namely, Kurt Lewin (*Field Theory in Social Science* and *Principle of Topological Psychology*), Dorwin Cartwright (*Modern Organization Theory*), and Festinger's work on sociograms.

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MATHEMATICAL METHODS IN SMALL GROUP PROCESSES. Edited by Joan Criswell, Herbert Solomon, and Patrick Suppes. Stanford, California: Stanford University Press, 1962, 369 pp., \$9.75.

TYPES OF FORMALIZATION IN SMALL GROUP RESEARCH. By Joseph Berger, Bernard P. Cohen, J. Laurie Snell, Morris Zelditch. Boston: Houghton Mifflin, 1962, 169 pp., \$4.50.

Both these books are the result of group action among mathematical experts and leave this reviewer in a state of healthy awe at the degree of specialized knowledge required for a thorough study of group processes.

The outline of types of formalization offered in the second volume is particularly useful and important for the clinician who wants to do research. He is asked to decide whether his research serves: (1) to give more precise meaning to a basic concept (explicational model), (2) to describe a recurrent specified instance of a crucial phenomenon (representational model), or (3) to formulate a theory and relate it to observations (theoretical construct model). This kind of self-examination in clinical research is so

very much needed that it might well be carried further, to an analysis of levels of observation used as a basis for generalization.

On the whole, the examples given in these two volumes will be hard to follow for any but the most mathematically sophisticated readers. This work would have been more generally useful and applicable if the writers had remembered that most clinicians are mathematical novices.

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GOALS AND PROBLEM TRAINING: THE ROLE OF GROUP PSYCHOTHERAPY IN A MENTAL HOSPITAL. By *Curt Boenheim*. Columbus, Ohio: Columbus State Hospital, 1962, 55 pp. (Paperbound).

This handbook describes Dr. Boenheim's theoretical position, the types of groups used at the Columbus State Hospital, and the methods by which group psychotherapy is organized and taught there.

For this reviewer, the actual protocols of group sessions, training workshops, and doctors' groups are the most interesting parts of the manual. The theoretical discussions, on the other hand, are neither fully developed nor well thought through. This is possibly due to the author's need for brevity, although there is a much more adequate account of general dynamic theory than of group psychotherapy. For instance, although selection is emphasized as extremely important, the criteria of selection for different types of group are not well spelled out. Similarly, the case material is full of inconsistencies and does not enable one to obtain a clear picture of the patient's dynamics nor how changes were brought about through the medium of group psychotherapy, although the changes in functioning are well described.

The training program seems a comprehensive and useful one and worth considering by those who are planning to set up programs. One theoretical point of difference between the author and the reviewer is the author's assumption that the use of co-therapists is universally accepted as a valuable method of training. This is by no means so. Some teachers reject co-therapy altogether. This reviewer's opinion is that, while co-therapy can be useful, it can also be a damaging and destructive experience and that the purpose and selection of co-therapists should always be carefully thought through.

Although this handbook has very definite shortcomings, it is thought-provoking and should prove a useful adjunct to the practitioner's library on group psychotherapy.

BERYCE W. MACLENNAN, PH.D.
Washington, D. C.

HEAL THE HURT CHILD. By *Hertha Riese*. Chicago: The University of Chicago Press, 1962, 615 pp., \$10.00.

"Untreatable children," children not amenable to treatment in the traditional child guidance clinic, are offered a combined psychotherapeutic and educational experience in the day-care approach of the Educational Therapy Center in Richmond, Virginia. Dr. Hertha Riese, the psychiatric director, describes in rich detail the theoretical assumptions and methods that underlie treatment of the hopeless child and his family.

Healing the neglected, isolated, depressed child is a multidimensional endeavor. The connection between his emotional damage and the larger social disorder is given more than intellectual recognition; it is central in Dr. Riese's treatment. The children described in this volume are underprivileged Negro children. They are children not only isolated in the family, but also in the community. Dr. Riese's findings, however, are applicable to hurt children of all races and subcultures.

Parents who are discouraged about the world and their own role in it convey their hopelessness to children, who in turn perpetuate futility. In order to provide motivation for a new relationship with the world, the Center gives the child the opportunity to build up his self-esteem in a protective, permissive milieu which permits him to remain in the community while it shelters him at the height of his emotional solitude.

The main aspects of therapy delineated by Dr. Riese are careful diagnostic procedure and planning, and treatment which is flexibly geared to meet the needs of the child, whether it be one weekly session or thirty-five hours a week. The entire therapeutic staff establishes the need and desirability for day-care. The children accepted are those who cannot cope with school requirements but who can, with psychological support, live at home or in a foster home. Each child and parent is assigned to an individual or group therapist. Although the child has his own therapist, he is free to see any professional worker on the staff. These impromptu visits serve the purpose of letting the child know that he is excluded nowhere, as well as promoting his exploration of relationships.

Psychotherapy in small groups was explored first as an adjunct to or substitute for individual therapy. Larger groups were formed for growing children and adolescents who had undergone individual therapy. Where the expression of intense dependency needs was necessary, as with young children, the therapeutic group proved particularly successful.

Dr. Riese has covered a diversity of material in this book. Several chapters might well have been developed as separate monographs. She discusses the child's background and symptoms against the psychosocial economy of the family in its normal and abnormal aspects. She develops such themes as sex education and maturation, the child's relation to objects, and the problem of language. An interesting chapter on therapeutic education embraces reading techniques and the use of crafts in learning.

The appendix includes the dynamics of representative case histories,

illustrating such problems as severe sexual traumatization, pervasive maternal hostility, therapy with an asocial child. One is deeply aware in reading this clinical material that these are indeed hurt children who have been salvaged by the creativity and conviction of Dr. Riese and her therapeutic community.

BEATRICE LIEBENBERG
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Washington, D. C.

THE PSYCHOANALYTIC STUDY OF THE CHILD, Volume XVI. Edited by Ruth S. Eissler, Anna Freud, Heinz Hartmann, and Marianne Kris. New York: International Universities Press, 1961, 563 pp., \$8.50.

This is the sixteenth volume in the well-known series, and it is the largest of them all. It contains 26 papers; four come under the heading of "Contributions to Psychoanalytic Theory," six under "Aspects of Normal and Pathological Developments," and 16 under "Clinical Contributions."

The content of this volume is rich and varied, and the range of topics promises something of value for readers of different disciplines. Both researchers and clinicians will be impressed with "A Study of the Psychological Processes in Pregnancy and of the Earliest Mother-Child Relationship" by Grete L. Bibring et al. Rarely in psychoanalytic research does one find such clearly defined concepts and such a thorough collection of data. Clinicians may take note of one of the incidental findings of this study: patients gave strikingly different material to different workers. The conclusion is that when a parent can be seen only a limited number of times "there may well be a definite advantage to have [him] seen by more than one interviewer."

Frankel's paper "On the Development and Disturbance of Integration in Childhood" makes the necessary distinction between disturbances of integration due to (1) arrested development, (2) imbalance of development, (3) regression from more mature development, and (4) splitting of the ego in the defensive process. This emphasis is timely because some psychoanalytic writers seem to use the same concept of defenses in talking about early infancy, before integration has taken place, and in describing adult patients, who have achieved some level of integration prior to their illness.

Dorothy Burlingham's paper is outstanding in both substance and style. It comprehensively describes the personality development of the blind as compared to that of the sighted child. A paper by Provence and Ritvo, "Effects of Deprivation on Institutionalized Infants," not only lends support to the already known fact that lack of mothering is detrimental to the development of infants, but formulates hypotheses about the specific mechanisms by which the adverse effects are brought about.

Space does not permit individual evaluation of the sixteen papers in the clinical section, but they are virtual gold mines for the practitioner.

There are papers on the treatment of a blind child, a brain-damaged child, an autistic child, an orphaned child, identical twins, a boy whose leg was amputated, and a girl who first saw after an operation for congenital cataracts. And there are papers on grief, depression, dread of abandonment, and termination of treatment. In this section, a paper on "Screen Sensation" by Antony and on "Transference Resistance in Pre-puberty" by Brody are instructive as well as interesting. All in all, this volume is well worth possessing.

The one complaint that this reviewer has concerns the awkward style and unappetizing language of some of the papers. Granted that not every psychoanalyst can be a gifted writer, is it not the task of an editor to make sure that ideas are presented succinctly and in good form? When competition for space is so great, must the very same material appear both on pages 54-55 and on 63-64? And when paragraphs starting with, "To restate our position," are followed by sentences starting with, "To say it in other words," should not someone take a hint? To say it in other words, or to restate our position: the *Psychoanalytic Study of the Child* needs better editing.

HAIM G. GINOTT, Ed.D.
New York, N. Y.

DEVELOPMENTS IN PSYCHOANALYSIS. By Leon Salzman. New York: Grune & Stratton, 1962, 302 pp., \$7.75.

This is a welcome re-evaluation of Freud's major contributions, together with a fresh and original survey of post-Freudian developments in the field of psychoanalysis.

Salzman states that Freud's preoccupation with the id left the ego largely unexplored and that most recent developments in psychoanalysis are attempts to fill this gap. In re-evaluating Freud's contributions, Salzman presents the view that the id is not the mainspring of human motivation, as Freud believed, stating that the origin of human motivation resides in man's need to express and fulfill his potentialities. Freud saw the ego as dependent, at the opposite pole of the id and at war with it, in a battle between animal nature versus human nature. Current theorists see the id as an expression of man's deeper, unrecognized need, not in opposition to the ego but conjunctive and cooperative with it. This has profound consequences for the development of alternative hypotheses of personality development and for the nature of psychoanalytic therapy. The present trend in psychoanalytic thought is to see the basic problem in neurosis as the inability to love and live productively, an ability deeply repressed in the neurotic but which can be made available through therapy. The so-called instinctual nature of hostility and aggression is seen by Salzman as due to a frustrated search for love and a need to love others. The thesis that man is essentially evil and destructive is not supported by modern psycho-

analytic research. Nor does such research support the Freudian view of penis envy in women, as literally stated by Freud, or the concept of the inferiority of women to men.

The major contributions of the ego psychologists, Alfred Adler, Carl Jung, Karen Horney, Eric Fromm, and Harry Stack Sullivan, are described. Space does not permit even a brief summary of their contributions in this review, but it may be noted that ego psychology was initiated by Alfred Adler, who described the search for power as the major propelling force in the individual's struggle to achieve status, prestige, and feelings of superiority, and emphasized the individual's need to assert himself. Carl Jung's contributions extended the instinct theories and expanded the role of the ego in personality development. He recognized the spiritual and aesthetic needs of man, and saw them not as sublimated sex needs, as suggested by Freud, but as arising out of values and needs specific to man. Karen Horney discarded the biological orientation of Freud and postulated that the personality develops entirely in parent-child, child-adult, and adult-adult interaction. The motive power lies in the need to fulfill one's potentialities in a self-realization process. Horney's therapeutic conceptions are directed toward personality expansion and self-affirmation by unwinding the dictates of the "shoulds" and claims which maintain the neurotic structure through such mechanisms as the idealized image. Eric Fromm stresses man's great need for relatedness, and deals among other things with the problem of isolation and separation, which he feels can only be resolved through love. The basic ethic for man is seen by Fromm as the fulfillment of his potentialities, and Fromm has clarified the goals of therapy as an unfolding of man's potentialities. Sullivan stresses the interrelations of man as necessary for development and thus he postulates nothing except what can be observed in these interactions. He sees the self as initially growing out of the need to deal with anxiety produced in early life by the disapproval of significant adults. Therapy is viewed as interpersonal in character, dealing, among other things, with the resolution of parataxic distortions.

The group of post-Freudian therapists dealt with in this book all take exception to the instinctivist foundation of Freud's theory. They broaden personality with the dimension of culture, yet maintain the validity of man's biological nature and hereditary predisposition. They all see man as creatively driven, as striving to achieve his goals in the midst of culturally induced anxiety, which he minimizes to workable dimensions but does not entirely eliminate.

Provocative chapters are included which deal with sex, female psychology, homosexuality, love, hostility and depression, masochism, and therapy.

One of the many virtues of this book is the manner in which complicated problems are stated with simplicity, clarity, and brevity.

RICHARD G. ABELL, M.D.
New York, N. Y.

ADVENTURE IN PSYCHIATRY. By *Denis V. Martin*, London: *Faber & Faber*, 1962, 216 pp., 21/—.

MILIEU THERAPY IN SCHIZOPHRENIA. By *Kenneth L. Artiss*. New York: Grune & Stratton, 1962, 187 pp., \$6.00.

These books offer a fascinating contrast in attempts to better the lot of the schizophrenic patient. The American experiment was carried out in an Army setting under somewhat special research conditions and with a relatively favorable staff-patient ratio. Early schizophrenic patients were randomly selected for the experimental ward, which was limited to ten beds, and treatment was carried on for periods of up to six months. The British account concerns itself with a hospital near London with 2200 beds, 15 doctors, 194 male and 288 female nurses. There are 53 wards in all, with accommodation varying between 40 and 90 patients. Since 1955, an increasing number of the wards have developed on therapeutic community lines.

Both psychiatrists are well known and respected in their own countries and to some extent the two books highlight some of the differences in outlook to be found between the two countries. The American experiment represents a serious attempt to use current psychoanalytic knowledge and relatively intensive treatment methods as well as the social environment to bring about a change in the schizophrenic illness of a relatively small group of ten patients. The British experiment is not confined to any one clinical category but attempts to consider the total problems of a mental hospital population and the extent to which the best possible patient management and social treatment can be effected with a relatively small staff. As might be expected with such vastly different frames of reference the two books have many more differences than similarities, although both claim to take the milieu as their central theme.

Col. Artiss writes from the point of view of his own concept of therapy, and the staff is trained to complement his individual handling of the case. Most of the book is taken up with a description of two apparently successfully treated schizophrenics. Col. Artiss is unquestionably the leader and therapist throughout, basing his program even in the social setting on a preconceived concept of "treatment." Admittedly, as the book proceeds, it becomes clear how much Col. Artiss is learning from his own researches and those of his colleagues. In fact, his analysis of the problem of schizophrenia and his operational model for the growth of the schizophrenic process (pages 134 to 147) indicate the richness of this learning experience. Indeed, it would be an excellent plan for the reader to start with these pages which show a much more flexible and open-minded attitude than is implied from the early parts of the book.

Col. Artiss makes the basic assumption that the difference between the "normal" and the schizophrenic is really one of degree and that disturbances in thinking, feeling, and acting can be readily recognized in the ordi-

nary population. He postulates that "the manifest willingness to accept parental prerogatives and cooperate in a reciprocal role system between the 'namer' (parent) and the 'named one' (child) is variously referred to as respect, obedience, love, acculturation. Operationally from the standpoint of the child, it is the tacit acceptance of a *role* which is fundamentally *defined by others* in return for their assuming a series of vital responsibilities concerning his welfare." He goes on to point out that this process may not run smoothly; for instance, the child's fantasy life runs directly counter to it, much of it being devoted to his "being" Tarzan, Mother, Father, Doctor, etc. He sees parent and child struggling through this acculturation process and states that in the case of the nonschizophrenic child the battle for prerogatives is won by the parent, whereas the opposite holds for the schizophrenic child. Treatment then concerns itself with relearning in a social situation, with the adverse relationships between child and parent relived in the hospital setting; but first the individual must be helped to modify his prerogative and, instead of insisting "I am Jesus" or "I am William," to accept that he is a patient. Col. Artiss' results are impressive; of 42 treated patients, 64 per cent returned to duty.

Denis Martin, in contrast to Col. Artiss, gives us very little awareness of himself as a person. He talks entirely through his staff and patients, and one has the impression of a developing methodology which is the composite of the groups' increasing experience and skills. The book is simply written, with no medical jargon, and would be as easily read by a psychiatric aide as by more trained professional staff. Dr. Martin describes in detail the now all-too-familiar phenomenon of the ward which develops a new methodology of a more democratic, equalitarian kind meeting with tremendous resistance from the rest of the hospital, which is threatened by the prospect of change. He places great emphasis on the daily ward meeting of 20 to 60 patients, followed by a staff meeting to study what has happened in the ward meeting and to afford an opportunity for multidisciplinary training. Unlike Col. Artiss, he sees the doctor's role as essentially that of a consultant who is helping nurses and other staff personnel to achieve a more adequate role performance. The ward situation, as well as all the planned activities, are seen as part of treatment, and the role of the patient in helping with the treatment of other patients is emphasized.

The strength of Dr. Martin's book is its simplicity and the sincerity with which he approaches the problems of both patients and staff in a large mental hospital. Out of sheer necessity he has to make the best possible use of the social environment because trained staff to administer more sophisticated types of psychotherapy are simply not available. At the same time, he leaves the reader with the feeling that something approaching a methodology of treatment has been achieved by the daily examination of what is being done and why it is being done at all levels of staff and patient interaction.

To Col. Artiss, the social environment is utilized as an extension of the traditional psychotherapeutic approach. There is no question that

Denis Martin's book is ideal for the mental hospital where, as yet, little has been done to change from a custodial to a more therapeutic climate. Whether the methods which he describes are merely a preliminary to the more advanced treatment theory formulated by Col. Artiss can only be resolved through time.

MAXWELL JONES, M.D.
Melrose, Scotland

SCHIZOPHRENIA AS A HUMAN PROCESS. By *Harry Stack Sullivan*. New York: Norton, 1962, 372 pp., \$6.50.

Schizophrenia as a Human Process is a collection of fourteen papers by Sullivan published from 1924 to 1935. The editor, Helen Swick Perry, a former associate of Dr. Sullivan, has made a notable contribution in bringing these valuable but inaccessible articles together in one book. Her biographical introduction and the commentaries prefacing each chapter, as well as the foreword by the late Clara Thompson, make this book a welcome tribute to Sullivan and his pioneering research with schizophrenics.

The reviewer found all the papers stimulating and enlightening, but in this brief space only a few of the many significant themes can be mentioned. In the first paper, "Schizophrenia: Its Conservative and Malignant Features," published in 1924, Sullivan discusses the hopeful and preservative features of the schizophrenic illness. Sullivan's dedication was to the stimulation "of a new interest so that these patients will cease to be regarded as inexplicable and hopeless." Probably no psychiatrist has ever so clearly emphasized the importance of the general attitude of the physician toward the patient. This became the forerunner of Sullivan's famous theme of "interpersonal relations."

In a paper published in 1929, he observed that in every case of schizophrenia there occurs "a disaster to self-esteem." He depicted the breakdown, often utterly unexpected, and the acute panic, which may linger as chronic feelings of uncertainty in the victim.

Sullivan boldly related the plight of the schizophrenic to the general human condition of nonschizophrenic persons. He found common denominators in many social difficulties with those of the schizophrenic. He repeatedly pointed out the similarities between the socially detached and inadequate person, especially the juvenile and adolescent, and the schizophrenic. From his celebrated ward of acute schizophrenic males in Sheppard and Enoch Pratt Hospital, he discovered how the patients' social interaction with selected personnel promoted social recovery. He stated that such increased social insight was "sufficient to abolish the schizophrenic situation." These results were attributed to "the most commonplace of all things, our ordinary contact with our fellows."

In a paper published in 1931, Sullivan set forth his therapeutic methods as modifications of psychoanalytic treatment. The efficacy of his use of

a trained assistant is familiar to readers of this journal; the presence of an alternate therapist has become an acceptable practice. In "Tentative Criteria of Malignancy in Schizophrenia," he makes the clinically important observation that the problem of perverse cravings in the schizophrenic has to be evaluated more by the attitude of the ego than by the cravings themselves. "When the individual regarded his cravings as criminal or subversive the outcome was liable to be unfortunate."

Again and again, this volume dispels the notion that Sullivan overlooked the importance of the basic personality and the effects of the morbid disease process on it. But he persisted in his contention that it is the real life situation and the socio-cultural-environmental factors that are of primary importance.

In "Psychiatric Training as a Prerequisite to Psychoanalytic Practice," Sullivan stressed the value of combining psychiatric training with personal psychoanalysis, which is in effect an answer to Freud's comment: "our psychiatrists do not study psychoanalysis; we psychoanalysts see too little of psychiatric cases." In "Peculiarity of Thought in Schizophrenia," Sullivan sees schizophrenic thinking as a human process, not grossly different from thinking found in all individuals as manifested by reveries and dreams. The final chapter, "Cultural Stress and Adolescent Crisis" is an unpublished paper, a bitter diatribe against the hypocrisy of social and cultural institutions in their pernicious effects on adolescent breakdown.

This book is a vast source of rich clinical material from one of our most creative psychiatrists. It is heartily recommended.

SELWYN BRODY, M.D.
New York, N. Y.

IRRATIONAL DESPAIR: AN EXAMINATION OF EXISTENTIAL ANALYSIS. By Benjamin Wolstein. New York: Free Press of Glencoe, 1962, 212 pp., \$4.00.

Irrational Despair is an invective critique by an established psychoanalyst of the upstart existential movement in neo-analysis and psychotherapy. Wolstein stretches to book-length a critique of existential philosophy and existential therapy which could have been published in some pseudoscholarly journal for armchair polemics.

According to Wolstein, there is nothing constructive about the existential position, for the existential therapist has failed fully to explore the primacy of subjective feeling in the "I-Am" and the "I-Thou" relationship in therapy by not having calibrated his potentially valuable focus on "immediatization of experience" with established psychoanalytic knowledge. In view of Wolstein's two previous books, *Transference* (1954) and *Countertransference* (1959), readers will not be surprised that Wolstein considers regressive any approach that relegates to a secondary position the psychogenetic analysis of the interplay of transference and countertransference. He simply cannot conceive a valid approach to therapy which concentrates

on the here and now and does not interpret the immediate experience through the dark glasses of reconstructed history. To his mind, existential therapists who presumptuously dare to bypass the sacred conceptual edifices of psychoanalytic theory and practice ask for a good analytic dressing down. And Wolstein lets them have it.

Wolstein cannot see how the existentially oriented therapist can create change through a nonhistorical type of insight into the quality of encounter, the nature of togetherness in the here and now of the therapist-patient or therapist-group relationship, without giving it a derivative or defensive interpretation. In my own practice, I have noticed that sensing the nature of the immediate "I-Thou" encounter—especially in group therapy, gives patients valuable clues as to their unique quality of being-in-the-world, their unique selfhood. And this sensing of "Being-with-You" or with us or with me alone is the impetus for change not in spite of but because such sensing of the "I-Am" entails—in the words of Wolstein—"ubiquitous anxiety and unanswerable dread." The heuristic value of irrational despair associated with the insight, "I am nothing," lies in the anger action and search for self-actualization which it stimulates. In closing the author may be commended to ponder his own words: "Those who consider it impossible to sort out and assimilate the positive kernel of such [existential] views have directed their full attention to the pressing issues of psychoanalytic theory without further pursuing this detour to nowhere."

GEORGE R. BACH, PH.D.
Beverly Hills, Calif.



BOOKS RECEIVED

- PREVENTION OF HOSPITALIZATION. By *Milton Greenblatt et al.* New York: Grune & Stratton, 1963 (\$7.50) 195 pages.
- INDEPENDENT ADOPTIONS. By *Helen L. Witmer, Elizabeth Herzog, Eugene A. Weinstein and Mary E. Sullivan.* New York: Russell Sage Foundation, 1963 (\$7.50) 463 pages.
- MENTAL HEALTH CONSULTATION IN SCHOOLS: A RESEARCH ANALYSIS. By *Richard L. Cutler and Elton B. McNeil.* Michigan: The Oak Park Public Schools and the Michigan Society for Mental Health, 1963, 166 pages (paperbound).
- THE CONDUCT OF SEX. By *Lawrence K. Frank.* New York: Grove Press, 1963 (60c) 160 pages (paperbound).
- PSYCHOLOGICAL COUNSELING IN A SMALL COLLEGE. By *Eugenia Hanfman, Richard M. Jones, Elliott Baker and Leo Kovar.* Cambridge, Mass. Schenkman, 1963 (\$3.95) 141 pages.
- OCCUPATIONAL THERAPY. By *Gail S. Fidler and Jay W. Fidler.* New York: Macmillan, 1963 (\$4.75) 284 pages.
- MAN'S IMAGE IN MEDICINE AND ANTHROPOLOGY. Edited by *Iago Galdston.* New York: International Universities Press, 1963 (\$10.00) 541 pages.
- HANDBOOK OF MEDICAL SOCIOLOGY. By *Howard E. Freeman, Sol Levine and Leo G. Reeder.* Englewood Cliffs, N. J.: Prentice-Hall, 1963 (\$11.00) 617 pages.
- ASPECTS OF PSYCHOTHERAPY. By *I. Atkin.* Baltimore: Williams & Wilkins, 1962 (\$3.00) 108 pages.
- BACK OF HISTORY. By *William Howells.* New York: Doubleday Anchor, 1963 (\$1.45) 398 pages.
- PSYCHIATRY IN AMERICAN LIFE. Edited by *Charles Rolo.* Boston: Little, Brown, 1963 (\$5.00) 254 pages.
- MODERN PSYCHIATRY: A HANDBOOK FOR BELIEVERS. By *Francis J. Braceland and Michael Scott.* New York: Doubleday, 1963 (\$4.95) 360 pages.
- THE BODY AND ITS MIND: AN INTRODUCTION TO ATTITUDE PSYCHOLOGY. By *Nina Bull.* New York: Las Americas, 1962 (\$3.00) 99 pages.
- CHILDREN TELL STORIES: AN ANALYSIS OF FANTASY. By *Evelyn Goodenough Pitcher and Ernst Prelinger.* New York: International Universities Press, 1963 (\$4.00) 256 pages.
- NORMAL PSYCHOLOGY OF THE AGING PROCESS. Edited by *Norman E. Zinberg and Irving Kaufman.* New York: International Universities Press, 1963 (\$4.50) 182 pages.

A. G. P. A. NEWS

Edited by CHARLES G. McCORMICK, Ed.D.

NORTHEASTERN SOCIETY

A report from John A. Abbott, M.D., lists newly elected officers and executive committee members of the Northeastern Society for Group Psychotherapy, and a summary of four scientific meetings held during the winter of 1962 to 1963. Dr. Abbott has been elected Secretary of the Society and is to serve in that office for two years.

The two other officers elected in April of this year are Joseph Weinreb, M.D., President, and Joseph M. Zucker, M.D., Treasurer. Executive committee members elected for a three-year term are Norman A. Neiberg, Ph.D., and Henry U. Grunebaum, M.D. Stanley S. Kanter, M.D., Past President, continues on the committee *ex officio*.

Two scientific meetings were held last fall and two this year. Dr. Weinreb was chairman of a meeting on "Group Psychotherapy of Fathers: Problems of Technique." Dr. Grunebaum delivered the lecture, with John Spiegel, M.D., and Irving Kaufman, M.D., as discussants. In December of last year the subject of the meeting under the chairmanship of Eleanor Pavenstedt, M.D., was "Supervision of Beginning Group Therapists." A panel consisting of Sidney Levin, M.D., and Stanley S. Kanter, M.D., initiated discussion. Jacob Christ, M.D., and Stanley Kruger, M.A., served as discussants.

The two papers this spring, one in February, the other in April, were on "The Field of Group Psychotherapy," and "Closeness, Impulsivity and Depression in a Therapy Group." Elvin V. Semrad, M.D., Stanley S. Kanter, M.D., David Shapiro, and John Arsenian, Ph.D., formed a panel on the first; Max Day, M.D., and Frederick Loew led the second. Discussants, two for each panel, were Max Day, M.D., R. Freed Bales, Ph.D., Norman Bell, and Norman Neiberg, Ph.D.

SOUTHWESTERN SOCIETY

A report from Paul V. Ledbetter, M.S.W., Secretary-Treasurer, announces the Annual Meeting and Institute of the Society for October 5 and 6 in Dallas. S. R. Slavson will be the principal speaker.

The Southwestern Society includes members from a vast stretch of land: Little Rock, Arkansas and Mexico City, with Texas crowded in between. A unique system of "seminars" has been initiated to enable members in various centers to meet and exchange information. Some of them meet monthly. There are committees responsible for arrangements in Dallas-Fort Worth, Houston-Galveston, San Antonio, and Little Rock. Leaders are Robert MacGregor, Ph.D. (newly elected President of the Society), Rodger A. Moon, M.D. (President-Elect), and Stanley P. Gluck, M.S.W.

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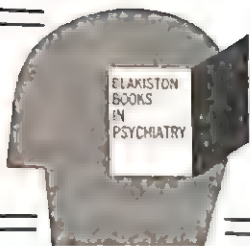
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